



**Link
Wentworth**
Providing homes, building futures.

11th June, 2024

ABN 62 003 084 928

Nurreen
Women's Domestic Violence
Accommodation and
Support Service
409a George Street
Windsor
NSW 2756
T 4574 8905
F 4777 8099

Chatswood
Level 10
67 Albert Avenue
Chatswood
NSW 2067

PO Box 5124
Chatswood West
NSW 2067

T 02 9412 5111
F 02 9412 2779

Penrith
Borec House
Level 1
Suite 1002
29-57 Station Street
Penrith
NSW 2750

PO Box 4303
Penrith Westfield
NSW 2750

T 02 4777 8000
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enquiries@
linkwentworth.org.au

Chatswood
Katoomba
Lithgow
Penrith
West Ryde
Windsor

Dear Paula,

Thank you for speaking with me this morning.
As discussed, you are only on the Housing wait in turn list. I have enclosed a Medical Assessment Form for you to get your Doctor to complete. You will need to lodge this with a completed Change of Circumstance form which I have also enclosed.

I have referred you to our Single Adult Service and somebody will reach out to you at some point although there is a bit of a wait currently. A support letter from Kimm at Pink Finns or the Social Worker at Nepean Hospital would also be most beneficial.

If you have any questions in the mean time, please do not hesitate to contact me.
Yours Sincerely

Lisa Minchenko
Caseworker (Nurreen)

Medical Assessment

This form is to be completed by the client's health care professional to provide information about the client's medical condition. Page 1 is to be completed by the client and the health care professional is to complete page 2 onwards. Please use BLOCK LETTERS and print in black or blue pen only. Please mark all relevant boxes with a ☒. If you need more space, please write on a blank page and attach it to this form. For information or assistance with this form, phone 1800 422 322, 24 hours a day, 7 days a week.

Client reference number

10032304

T-File number

140423648

Application reference number

?

Payment reference number

?

Name of social housing provider

WENTWORTH

Client details

Title
~~Mr, Mrs, Ms, Miss, Mx~~

PAULA

Last name
or family name

HICKS

First and middle name(s)

PAULA

Date of Birth

15/09/1964

Unit/House number

10

Street/Avenue

POST OFFICE RD

Town/Suburb

EBENEZER

Postcode

2756

Contact number

0428 354085

Email address

DCJ Privacy Notice

This privacy notice applies to the Department of Communities and Justice (DCJ) which includes the following entities: the Land and Housing Corporation and the Aboriginal Housing Office. DCJ and its related entities comply with NSW privacy legislation when collecting and managing personal and health information. The information we collect from you or from an authorised third party will be held by DCJ or the entity that collects it. It will be used to deliver services and to meet our legal responsibilities. We may also use your information within DCJ as a whole to plan, coordinate and improve the way we provide services. DCJ is also legally authorised to disclose information to outside bodies in certain circumstances.

Further information about your privacy rights can be found on the Department's website: www.facs.nsw.gov.au/site_information/privacy or by calling: 02 9377 6000.

Notice: Your personal information and any relevant health information provided on this form will be exchanged between social housing providers (public, community and Aboriginal housing) for the purpose of assessing your continuing eligibility for social housing and providing an appropriate service.

Authorisation

- I have read and understand the above notice.
- I give permission for medical details affecting my need for housing to be released to the above named social housing provider and, if necessary, for my doctor/health care professional to discuss these details on my behalf with the social housing provider.

Signature

Date

To the health care professional

The client has presented to the social housing provider requesting housing assistance. Social housing providers are committed to allocating suitable housing and creating sustainable tenancies. When completing this form it is important to take into account that information you provide will be most helpful to the client if it reflects your professional opinion. The information you provide will assist in accurately assessing the client's housing need, including particular housing features, such as type or location.

To assist in this process the following information is required.

Details of health care professional completing this form

Title
Mr, Mrs, Ms, Miss, Dr

Last name or family name

Organisation Name

Unit/House number

Street/Avenue

Town/Suburb Postcode

Phone Mobile

Email

Provider number

1. Please describe the professional service you provide to the client.

☐ General practitioner ☐ Specialist

☐ Other ☒ Allied health worker
give details

2. Please describe your field of expertise.

3. How long has the client been one of your patients?

☐ One consultation only ☐ Weeks

☐ Months ☒ Years

4. Please provide details of the client's medical condition and the affects it has on both their housing needs and their ability to access and sustain housing.

Name of medical condition(s)

1. THROAT CANCER + CHEMO SIDE EFFECTS
2. DEPRESSION + ANXIETY

Description of condition(s)

1. difficulty swallowing food or liquid; teeth fell out; weight loss; social anxiety; speech impairment
→ social isolation; loss of confidence
2. LOW MOOD; SUICIDAL IDEATION; PANIC ATTACKS.
WAKES UNABLE TO BREATHE

How the condition(s) affects the client's housing needs

UNABLE TO WORK; LOW INCOME
Financial stressors; can't pay bills →
Don't use heating or electricity if possible.
Overwhelmed by life stressors.

Frequency of visits to the practitioner

FORTNIGHTLY

Overall impact of the condition(s) on the client's wellbeing (please tick)

☐

Minor

☐

Moderate

☒

Severe

5. What is the likely duration of the condition(s)? (please tick)

☐

Short
(0 - 2 years)

☐

Medium
(2 - 5 years)

☒

Long
(5 years or more)

6. Do any of the above medical conditions restrict the client from accessing the required health service by walking or taking public transport?

☐

Yes
give details

☒

No Go to 7.

7. Is the client's current accommodation exacerbating their medical condition(s)? (e.g. lack of room for specialised medical equipment)

☒

Yes
give details

☐

No Go to 8.

DILAPIDATED PROPERTY; cold, damp, no insulation; rats, mice, vermin
unsanitary. Impacts physical + mental health. Health hazard in immunocompromised person.

8. Is the client's mobility restricted?

☐

Yes
give details

☒

No Go to 9.

9. Can the client manage steps/stairs?

☒

Yes
if yes, how many

☐

No Go to 10.

☐

1-2

☐

3-5

☒

6 or more

10. Does the client need accommodation that is modified? (e.g. hobless shower, 1/4 turn taps, wheelchair access)

☐

Yes Go to 11.

☒

No Go to 12.

11. Is a low or high level of modification required?

☐

Low: Mainly additions, suitable for a "handy man" e.g. lever taps, grab rails, accessible door handles, painting of door frames or steps to improve visibility

☐

High: Likely to involve alterations and/or building works e.g. alterations to allow access for a wheelchair, or installation of a hoist, full kitchen or bathroom modifications such as changing cupboard heights or removing shower hob and screens

Give details

12. Does the client's condition(s) affect their ability to look for suitable private rental accommodation?

☒

Yes
give details

☐

No Go to 13.

Unaffordable - on DSP
Anxiety increased

13. Does the client have extra expenses because of their medical condition(s)?

☒

Yes
list the expenses incurred on a regular basis which may cause financial hardship to the client

☐

No Go to 14.

Medication
Travel expenses
Dental work.

14. Has anyone in the household reached, or is likely to reach the annual Medicare Safety Net threshold by 31 December of this year? (See www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets/what-are-thresholds).

☐

Yes
give details

☐

No Go to 15.

NOT KNOWN

15. Has anyone in the household reached, or is likely to reach the annual Pharmaceutical Benefits Scheme Safety Net threshold by 31 December of this year? (See www.servicesaustralia.gov.au/individuals/services/medicare/pharmaceutical-benefits-scheme/when-you-spend-lot-pbs-medicines).

☐

Yes
give details

☐

No Go to 16.

Not Known

16. Does the client need to live in a particular area to access support services?

☒ Yes
what location
is required?

☐ No Go to 17.

HAWKESBURY - OVER 55s village.

17. Has an independent living skills assessment been done?

☐ Yes
attach the
independent living
skills assessment

☒ No Go to 18.

18. Is the client able to live independently without support?

☒ Yes Go to 24.

☐ No
tick required support

☐ Personal care

☐ Cooking

☐ Shopping

☐ Cleaning

☐ Financial
management

☐ Identifying
unsafe
situations

☐ Other
give details

☐ Transport

19. Does the client currently have support for these functions?

☐ Yes Go to 20.

☒ No Go to 21.

20. Who provides this support?

☐ NDIS

☐ Carer

☐ HASI

☐ Other

Name of support
person/provider

21. Does the client currently have a carer?

☐ Yes

☒ No Go to 24.

22. Is the carer (please tick)

☐ Part time

☐ Full time

☐ On a needs
basis

23. Does the carer live with the client?

☐ Yes

☐ No Go to 24.

24. Do psychological issues affect the client's ability to cope?

☒ Yes

☐ No Go to 28.

25. Does the condition(s) require medication for the client to live independently?



Yes

give details



No

Go to 26.

Medication for mood stability + anxiety.

26. Is the client's condition(s) supported by other health professionals?



Yes

tick all that apply



No

Go to 27.



Mental health workers



Counsellors



Psychiatrists



Other health professionals

give details

Pink FINNS Cancer Charity.

27. Does the client have a particular dwelling requirement as a result of the condition(s)?



Yes

give details



No

Go to 28.

Warm + safe
Over 55 village (to be away from DASH estates is likely residents is drug + alcohol issues). Has a dog - important for mental health → needs garden.

28. Would you like to add further comments to support the client's needs?



Yes

give details



No

Go to checklist.

Paula has been on the housing list for 11 years. Her needs are now urgent due to health challenges.

Checklist

If appropriate, have you attached copies of relevant documentation such as:



Independent living skills assessment



Occupational Therapist's report detailing required modifications



Other documentation

give details

Practitioner's name

MICHELLE HOOKHAM.

Signature

Date

01/07/2024.

Thank you for taking time to complete this form