Part 2 of HMD-Form 1

Healthcare Professional (A)

NOTE: Please type this form when completing, but if writing you must use block capitals to ensure legibility.

This section must be completed by a Healthcare Professional.

Details of Healthcare Professional completing this form:

First name

Surname

Name of Organisation

Occupation

Registration Number

Email

Telephone

Please identify the person to whom you are providing professional healthcare services:

First name

Surname

PPS number

Date of Birth

Please indicate the professional service you provide to the disabled person or person with a medical condition, and the duration of time they have been engaged with your service.

Duration

Current Accommodation

In your professional opinion, is the accommodation in which the person is residing impacting negatively upon the person's disability or medical condition?

Yes ☐ No ☐

If yes, please explain below, and indicate whether you have visited their current accommodation:

Accommodation Needs

Based upon the information outlined above, in your professional opinion, how would moving to other accommodation meet the accommodation needs of the disabled person or person with a medical condition? Considerations for this may include:

- **Location (e.g., Proximity to amenities and services)**
- **Type of housing (e.g., Wheelchair liveable, wheelchair accessible, level access accommodation, standard accommodation)**
- **Design of housing (e.g., Accessibility features or other specific features, including additional bedrooms)**

Please detail below:

Support Needs of the Applicant

Are supports currently needed to enable the disabled person or person with a medical condition to live independently?

Yes ☐ No ☐

If yes, please provide details of support care package below:

Will the disabled person or person with a medical condition need any additional or new supports? Please provide details of the services you envisage will provide those supports.

Yes ☐ No ☐

Please provide details below:

Healthcare Professional Declaration

I declare that the information and details I have provided on this form are correct and true.

I agree to the local authority contacting me, if necessary, to verify the details I have provided.

Signature

Date

Please provide stamp from your service below if available:

If you require extra space to complete the form, please include additional pages.