


IN THE GRENFELL TOWER INQUIRY

ML/3

AHR Cat C

SUITABILITY RE-ASSESSMENT			
Date 18/6/12	HML Ref No.		1 Bed required mob CAT 1
Main Applicant	MONICA LOKKO		
Other household members/ relationship to applicant	DAUG HEBS OUT QUITE A LOT WITH CARE & STAYS OVER SUNDAY.  <u>3 GREENFELL</u>		
Current T Ref (if applicable)	Current TA Address (if applicable)	Room 368 CORPORATE HOTEL W8 5SY	
Name of person requesting this re-assessment	Clearly state <u>why</u> this re-assessment has been requested.	Scarsdale Place	

EDUCATION	
Child's Name and DOB	School attended (Please make note if studying for exams: GCSE/A-Levels)

How do the children currently travel to school?			
Does any child in this household have special educational needs?		Details <ul style="list-style-type: none"> • Who • Where • How often 	
Please provide details of extra care required or SUPPORT plans in place.			
CHILDCARE ARRANGEMENTS			
Any current childcare arrangements in place?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Details <ul style="list-style-type: none"> • Who Provides • Where • How often/Hours • Cost 	
MEDICAL INFORMATION			
Does anyone in the household have medical problems?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Please provide summary details below	
WHO/CONDITION	HOW LONG	TREATMENT / MEDICATION/ MEDICAL EQUIPMENT REQUIRED?	IS TREATMENT ONLY AVAILABLE IN RBKC?
• ALZHEIMER IN HIPS & KNEES.	SINCE 2013	ZIMMERFRAME / WALKER.	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
• DEPRESSION / MIGRAINES.			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>
			Yes <input type="checkbox"/> No <input type="checkbox"/>

			Yes <input type="checkbox"/> No <input type="checkbox"/>															
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			Yes <input type="checkbox"/> No <input type="checkbox"/>															
Can any care package/healthcare options be transferred?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <i>DOES NOT WANT TO LEAVE HER MEDICAL CENTRE</i>	If yes, would transfer of care package/healthcare options severely impact on ability to engage with treatment/care plan? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																
Can all household members use a lift?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	If no, please provide details. (Evidence must be provided) <ul style="list-style-type: none"> Who <i>NOT SINCE THE FILE - WILL NOT HAVE BEEN GCD FOR USE</i> How long has this been a problem Has treatment been sought/given 																
Can all household members manage stairs?	Three flights or more (36 steps or more) <input type="checkbox"/> Two flights (approx 24 steps) <input type="checkbox"/> One flight (approx 12 steps) <input type="checkbox"/> No flights <input checked="" type="checkbox"/> <i>NO STAIRS</i> Six steps <input type="checkbox"/> Difficulty climbing two steps <input type="checkbox"/> (Need for internal step free? <input type="checkbox"/>)																	
Does any household member have difficulty walking?	Indoors? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Outdoors? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	If yes, please provide details. <ul style="list-style-type: none"> Who <i>MONICA - MAY NEED WALKER</i> Do they use mobility aids? <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">AID</th> <th style="width: 33%;">INDOORS</th> <th style="width: 33%;">OUTDOORS</th> </tr> </thead> <tbody> <tr> <td>STICK(S)</td> <td></td> <td></td> </tr> <tr> <td>CRUTCHES</td> <td></td> <td></td> </tr> <tr> <td>FRAME</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> </tr> <tr> <td>WHEELCHAIR*</td> <td></td> <td></td> </tr> </tbody> </table>		AID	INDOORS	OUTDOORS	STICK(S)			CRUTCHES			FRAME	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	WHEELCHAIR*		
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WHEELCHAIR*																		
*If the household includes a wheelchair user please complete the below																		
Type of wheelchair used: <input type="checkbox"/> Electric Scooter <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> A wheelchair that someone has to push <input type="checkbox"/> A wheelchair the user propels themselves																		
How long have they used the wheelchair?																		
How did they get the wheelchair?																		