



REFERRAL FOR HOUSING SUPPORT

SUSTAIN
CONSORTIUM

This form must be completed for all referrals for housing related support. Areas marked * are compulsory – forms without this data cannot be processed

To be completed by SUSTAIN co-ordinator	Client ID		Date received	
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PERSON NEEDING SUPPORT	
*NAME	
*DOB	
*GENDER	<input type="checkbox"/> male <input type="checkbox"/> female
*Address (prior to start of service)	
*Postcode	
Telephone No	
Preferred communication/contact method (eg telephone, letter, email etc)	
Language (if not English)	
*Housing Status	<input type="checkbox"/> Rented <input type="checkbox"/> Homeless <input type="checkbox"/> Owner occupier <input type="checkbox"/> Other
Landlord type	<input type="checkbox"/> RSL <input type="checkbox"/> Private <input type="checkbox"/> Local Authority <input type="checkbox"/> Other
*Is the person in receipt of Means Tested Benefit? Please indicate	<input type="checkbox"/> HB <input type="checkbox"/> CTB <input type="checkbox"/> JSA <input type="checkbox"/> IS <input type="checkbox"/> Pension Credit <input type="checkbox"/> Working TC <input type="checkbox"/> Other <input type="checkbox"/> Not known

REFERRING AGENCY	
*Referral date (1 st contact)	
REFERRAL ROUTE if not referring agency	<input type="checkbox"/> individual named on form <input type="checkbox"/> other, please state
*REFERRING AGENCY inc. department	
*Address	
*Postcode	
*Contact Name	
*EMAIL	
*Telephone No	
*Has the referral been passed to another provider?	<input type="checkbox"/> yes <input type="checkbox"/> no
*If yes, who?	

SP Accredited Providers only	
*Have you carried out a formal assessment?	<input type="checkbox"/> yes <input type="checkbox"/> no
*If no, are you planning to assess?	<input type="checkbox"/> yes <input type="checkbox"/> no
Is needs/risk or support plan available?	<input type="checkbox"/> yes <input type="checkbox"/> no
ID of service being considered?	
Do you consider this referral urgent?	<input type="checkbox"/> yes <input type="checkbox"/> no

*Eligible Current Support Needs which have been identified to Prevent: indicate all that apply			
Housing Situation		Staying Safe	
1a. Tenancy failure	<input type="checkbox"/>	3a. Risk of domestic abuse	<input type="checkbox"/>
1b. Risk of losing accommodation	<input type="checkbox"/>	3b. Risk of harm from others	<input type="checkbox"/>
1c. Referral to Housing Option/Homelessness Team	<input type="checkbox"/>	3c. Risk of self-harm	<input type="checkbox"/>
Health & Well-being		3d. Risk of offending	<input type="checkbox"/>
2a. Risk of increased domiciliary care or home care	<input type="checkbox"/>	Economic Well-being	
2b. Risk of needing residential or nursing care	<input type="checkbox"/>	4a. Deteriorating financial position	<input type="checkbox"/>
2c. Presentation to Accident & Emergency services	<input type="checkbox"/>	4b. Risk of long-term worklessness	<input type="checkbox"/>
2d. Unplanned hospital admissions	<input type="checkbox"/>		<input type="checkbox"/>

*Child or Adult Protection Issues	
Has a potential need for a Child or Adult Protection referral been identified?	<input type="checkbox"/> YES <input type="checkbox"/> NO
If so, has an initial referral been made?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the service user pose a potential risk to others?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Has any other potential risk been identified? Please give brief details	<input type="checkbox"/> YES <input type="checkbox"/> NO

Statutory Frameworks:			
Has the applicant been accepted as requiring services under the following statutory frameworks (tick all appropriate)			
Care Programme Approach or subject to 117 Aftercare duty	<input type="checkbox"/>	Statorily Homeless and owed a main homeless duty	<input type="checkbox"/>
Probation Service or Youth Offending Teams	<input type="checkbox"/>	Relevant Child	<input type="checkbox"/>

Referral Pathways & Supporting Documentation:			
Please tick if the applicant has been referred via any of these pathways or if you are attaching any of the following supporting documentation (tick all appropriate)			
Supporting Documents	Available	Attached	Referral Pathways
Care Plan Assessment	<input type="checkbox"/>	<input type="checkbox"/>	Refuge Online//West Mercia WA <input type="checkbox"/>
Choice Based Lettings Registration	<input type="checkbox"/>	<input type="checkbox"/>	16+ Co-ordinator <input type="checkbox"/>
Common Assessment Framework	<input type="checkbox"/>	<input type="checkbox"/>	SRF please specify <input type="checkbox"/> Mental Health
Community Care Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Offenders
Homeless Assessment	<input type="checkbox"/>	<input type="checkbox"/>	RESIT <input type="checkbox"/>
Risk Assessment	<input type="checkbox"/>	<input type="checkbox"/>	Other Referral Process, Please state: <input type="checkbox"/>
Supporting Statement (Personal or Referring Agent)	<input type="checkbox"/>	<input type="checkbox"/>	

Relevant Information of any kind to support Referral:
For example, include details of any risks, disabilities (such as sensory impairment), special needs or requirements (eg female support worker)

*Equal Opportunities Monitoring Section				
Shropshire Council is committed to a policy of Equal Opportunities. The purpose of the following questions is to help us monitor our equal opportunity policy to ensure that our service is accessible to all sections of the community. This is sensitive and personal data and will be treated with the utmost confidentiality in line with the requirements of Data Protection legislation. The data will only be used for general statistical and monitoring purposes. The information will not be used in the assessment process.				
Ethnic Origin – How would the person being referred describe their ethnic origin?				
White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Gypsy/Roma <input type="checkbox"/> Other <input type="checkbox"/> Any Other Ethnic Background	Mixed Heritage <input type="checkbox"/> White and Asian <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> Other	Asian, Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Other <input type="checkbox"/> Do Not Wish to Disclose Ethnic Origin	Black, Black British <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other	Chinese <input type="checkbox"/> Chinese
Disability – does the person being referred consider they have a disability?				
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not wish to declare		If yes, please indicate type of disability		
<input type="checkbox"/> Physical Disability <input type="checkbox"/> Learning Difficulties <input type="checkbox"/> Mental Health Problems	<input type="checkbox"/> Chronic Ill Health <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> HIV / AIDS	<input type="checkbox"/> Mobility Problems <input type="checkbox"/> Other Disability <input type="checkbox"/> Registered Disabled		

*Data Protection & Confidentiality Statement:	
The person named on this form <u>must</u> be aware of this referral and give permission to share this information with relevant agencies relating to this referral	
Has permission to share data been given? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>If no, you should replace the name with a unique reference code before sending to the VRON or hold the form until permission is granted</i>	
Applicant Signature (if available)	Date
*Form Completed by: Name (print Contact No.	
Signature	Date

For queries or questions, please contact Liz Darbyshire, (SUSTAIN Consortium Co-ordinator - Severnside) 01743 285159
 Fax completed forms to 01743 285010 or contact Liz Darbyshire for details of email encryption