





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

PERSON NEEDING HOMELIFE SUPPORT	
*NAME	
*DOB	
*GENDER	<input type="checkbox"/> male <input type="checkbox"/> female
*Address (prior to start of service)	
*Postcode	
*Tel 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"/> JSA <input type="checkbox"/> Pension Credit <input type="checkbox"/> Other	<input type="checkbox"/> CTB <input type="checkbox"/> IS <input type="checkbox"/> Working TC <input type="checkbox"/> Not known
REFERRED BY		
*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		
*Telephone No		
*Email		
*SIGNATURE		

HOMELIFE ASSESSED SUPPORT NEEDS <small>please give as much information as possible</small>	
	In the home – eg cooking, cleaning, washing, ironing
	Accompanied Visits – eg shopping, health appointments, walking, trips out
	Correspondence – eg understanding letters, paying bills, arranging appointments
	Rebuilding Confidence and Keeping You Safe – eg leaving hospital, moving home, getting out and about, living with an illness or disability, making new friends

Child or Adult Protection	
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
Has any other potential risk been identified? If yes please give brief details	<input type="checkbox"/> YES <input type="checkbox"/> NO

Other Relevant Information

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 Housing Group 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
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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 **must** 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? Yes No

Applicant Signature (if available) **Date:**

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Assessment Result

Service Not Suitable	<input type="checkbox"/>	Signposted	<input type="checkbox"/>
Declined Service	<input type="checkbox"/>	Support refused – need or risk to high	<input type="checkbox"/>
Support Required – ready to place	<input type="checkbox"/>	Any Risks Identified? If yes please indicate below	<input type="checkbox"/>

Assessment for exemption for VAT on services provided by the Homelife Support Service

Please confirm if the individual is (tick all that apply):

Elderly	<input type="checkbox"/>	Sick	<input type="checkbox"/>	Distressed	<input type="checkbox"/>	Disabled	<input type="checkbox"/>
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Please indicate below what is their Health Condition / Medical Need:

Does the individual have the ability to perform the Support Task unaided? YES NO

This assessment has shown that the recipient is unable to carry out the task safely or adequately without significant pain or discomfort and that this inability presents a risk to their health or welfare.

Please note below any further information:

***Assessment Completed by:** Name (print):

On behalf of Shropshire Housing Group

Signature: **Date:**

The above named person is an appropriately trained person as defined in HMRC's guidance.