

Floating Support Referral form



Applicants name (s):		Referrer name:	
1.			
2.			
Applicant 1 D.O.B:	/ /	Referring Organisation:	
Applicant 2 D.O.B:	/ /	Agency/organisation name: Address: Tel No: Email:	
Applicant 1 NI No:			
Applicant 2 NI No:			
Applicants contact details:			
Address: Postcode: Tel No: Best Method of contact: Call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Letter <input type="checkbox"/>			
Who is your Landlord:			
If pregnant, E.D.D			
Name of 1st Child		D.O.B	
Name of 2nd Child		D.O.B	
Name of 3rd Child		D.O.B	
Name and contact details of Social Worker (if applicable)			
Name and contact details of Health Visitor (if applicable)			
Is there a CAF/TAC or Child Protection Plan in place?		<i>Details</i>	
Yes	No		

Current financial status:

Please detail full income details (work related income, welfare benefits etc)

Current housing status (please tick):

Rough sleeping		shared accommodation	
sofa surfing		private landlord tenancy	
living with family		Housing association tenancy	
Job Loss		Temp Accommodation Terminated	
House Repossessed		Landlord Sold Property	
Bedroom Tax		Evicted (Arrears)	
Evicted (breach of Agreement)		Evicted (anti-social behaviour)	
Bail Conditions		Leaving Bail Hostel	
Leaving Prison		Leaving Care/Hospital	
Relationship Breakdown (couple)		Domestic Abuse (victim)	
Other Abuse (Victim)		Domestic Abuse (perpetrator)	
Family Intervention		Homeless Immigrant	
Overcrowding		Habitual	
Unliveable Conditions		Traveller	
Out of Area		Housed	
Emergency Housing		Other Reason	
Temporary accommodation		Unknown	

Have you received support before? Yes/No

If yes: in the last 6 months in the last 12 months over 12 months ago

Who provided your support?

	Please tick		Please tick
Different support need		Change in health	
Current crisis		Change in financial situation	
Didn't meet needs previously		Change of circumstances	

Individual requirements/health & well being			
	Please tick		Please tick
Mental health issues		Physical/sensory disability	
Learning disability		Acquired brain injury	
Young person (under 18)		Young parent (16-18yrs)	
Reading or writing difficulties		Communication/language barriers	
Older person		Other (please provide details)	
For any requirements 'ticked', please provide details:			

Network of Support/other agencies involved			
Agency/ organisation	Name/key contact	Contact Details	Please tick if you do <u>not</u> want us to contact

Needs Assessment - What outcomes would the client like to achieve <i>(Please tick all that apply)</i>			
Successfully maintain own accommodation and reduce the risk of homelessness		Develop the skills needed to live independently and as an integral part of the community	
Develop skills to better manage money, budget and minimise debts		Engage in meaningful activity and make a valuable contribution	
Engage in education and/or training to improve the chances of gaining employment, including work placements and apprenticeships		Improve quality of life, including improved health and emotional well being	
Reduce the risk of social isolation by building and maintaining a range of social networks		Maximise independence and minimise the need for higher levels of support, care or hospital admissions	
Minimise the risk of offending		Stay safe and minimise the risk of harm	
Exercise control over own life		Better able to manage risk	
Participate in leisure, faith, cultural or informal learning		Increase motivation	
Feeling more involved		Better able to control anger and/or aggression	
Increase confidence		Manage physical health better	
Achieving positive, social and personal relationships		Manage mental health better	

To feel less reliant on other services		Manage drug or alcohol misuse better	
Comply with statutory/court orders		Other.....	
Help to find other help and support		Other.....	

Additional Comments:

Risk Indicators – This information is required to allow support workers to prepare for the assessment fully. Please give as much detail as you are aware of especially where there may be concerns for lone working.

Please note lack of information may result in a delay of the referral being processed.

***If you are making this referral for an individual that is not known to you and/or you do not consider it appropriate to complete this section, please tick here (Please ensure the 'Network of Support/other agencies involved' details are completed in full as this will allow us to make the necessary enquiries regarding risk.**

Is there any history or evidence of the following?					
	Yes	No		Yes	No
Violence or Aggression			Self Harm		
Arson			Sex Offences		
Domestic Abuse			Criminal Offences (other)		
Substance / Alcohol use			Statutory Orders		
Mental Health			Hazards from Others (friend/family/visitors)		
Any Pets Owned?			Other (please specify)		

Please give further details including what these risks may mean to support providers, how can we manage these risks and how any current or future support is/may minimise these risks:

Monitoring our Services

We are committed to providing a service, which is fair and available to everyone. To help us monitor this, please answer the following questions. Your response will be kept confidential, however from time to time we will contact a sample of responses who have not taken up for the service to ensure that there is fair access to the service.

Gender Male Female
Do you consider yourself to have a disability? Yes No

Ethnic origin of applicant:

- A – White British Irish Other
- B – Mixed White and Black Caribbean White and Black African White and Asian Other
- C – Asian or Asian British Indian Pakistani Bangladeshi Other
- D – Black or Black British Caribbean African Other
- E – Chinese or other Ethnic group Chinese Other
- F – Gypsy / Romany / Irish Traveller
- G – Refused

Confidentiality – Data Protection Act 1998

We deal with personal and sensitive information in line with the Data Protection Act 1998. Personal and sensitive information is what you have told us about yourself, or what other organisations have told us about you, or may tell us in the future.

We will always hold and use information in accordance with the law. This may include using it for statistical or research purposes, and to update our records. We may need to share some details about you with other organisations that have the right to see them, such as the police or social services. We will never give details to companies outside of the Thrive Partnership unless you have given permission.

Customers have the right to see any personal information held about them and to correct any that is wrong. However, will not be able to see information that others have given us in confidence. We may make a small charge for finding and copying the information.

Signature of applicant 1:	Date:
Signature of applicant 2:	Date:
Signature of referrer:	Date:
Have you filled out this form on behalf on the applicant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, I confirm that I have explained to the applicant (s) what support the service can provide and why they have been referred.	

Thank you for taking the time to complete this form. We aim to acknowledge receipt of referrals to both referrer and applicant within 5 days of receipt.

Please return form to:

**Thrive
Morson House Office
14/16
Market Street
Oakengates
TF2 6EL**

Email: thrive@staytelford.co.uk

Tel: 01952 504325

Office use only

Customer 1 Reference No:	Date logged:
Customer 2 Reference No:	Date logged: