



CUSTOMER REFERRAL FORM

Twenty-Fifth Avenue is the assessment route for people in need of Housing Related Support and will:

- Complete an initial assessment, through a face to face meeting to identify the priority housing support need when there is homelessness.
- Provide housing related support for people who are homeless or at serious risk of homelessness which includes:
 - i. Support with accessing short term accommodation, where a person is homeless; ii. Support with move on; setting up and maintaining a tenancy;
 - iii. Support with developing domestic and life skills, to help maintain and establish accommodation; iv. Support in accessing community services and developing independence.

Service Eligibility

- You must be over 18 to access floating support, and homeless or at serious risk of homelessness to access short term accommodation where appropriate.

Consent to share must be given before referral can be processed:

I give permission to Twenty-Fifth Avenue to share information contained within this referral and assessment and to contact any other relevant authority in my care and support.

I understand that the information on this form is true and correct and that any false or misleading information may lead to:

- My referral being cancelled
- If an offer of support has been made, then it may be withdrawn.

I understand that the information on this form will be recorded on Twenty-Fifth Avenue system.

I understand the above.

Signature of person being referred:

Date:

Date of Referral:

Personal Details

Mr/Mrs/Miss/Ms/Other (Name).....

Address:

.....

Posted Code: National Insurance:

Telephone Number: Email Address:

Date of Birth:

Has this referral been discussed with the person referred? Yes No

Do you require feedback: Yes No

Client Group, please tick appropriate group (s)

Young Person (18-25)			Mental Health Issues		
Adult			Offender or risk of Offending		
Single Homeless			Substance misuse		
Victim of Domestic Violence			Ex-convict		

Please provide details about your mental health difficulties and the support you would like to receive?

Why is this person homeless?					
Tenancy Breakdown	<input type="checkbox"/>	Family breakdown	<input type="checkbox"/>	Eviction	<input type="checkbox"/>
Fleeing violence	<input type="checkbox"/>	Leaving Hospital	<input type="checkbox"/>	Sofa surfing	<input type="checkbox"/>
Homeless after care	<input type="checkbox"/>	Sexuality issues	<input type="checkbox"/>	Financial issues	<input type="checkbox"/>
Leaving custody	<input type="checkbox"/>	Harassment	<input type="checkbox"/>	Leaving prison	<input type="checkbox"/>
Waiting for accommodation	<input type="checkbox"/>	Relationship breakdown	<input type="checkbox"/>	Racism	<input type="checkbox"/>
Other (Please give details):					

Referral Details
 Referring Agency:

Contact Name:

Address:

.....Post Code:

Telephone Number:Relationship to Clients:

Housing History (please list last three years address history):

Where/Type of accommodation	Length of Stay	Reason for leaving

Housing

What sort of accommodation are you in now?	Council/housing associated		Lodger		
	Owner Occupier/shared owner		Living with family and/or friends		
	Temporary accommodation		Acute Health center		
	Supported Housing		Night shelter/hostel		
	No fixed abode		Rough sleeper/squatting		
	Private landlord		Refuge		
	Sanctuary Tenant (Give details)				

Other accommodation (Give details)			
If you are currently in prison/offender's institution, when will you be released?			
Are you currently homeless? If yes, please give details and state how long you have been homeless	Yes No	<input type="checkbox"/>	
Current address (If applicable)		Post Code	How long have you been at this address?

Is your current accommodation inappropriate for any of the following reasons?	Relationship breakdown Households living apart Currently living in an adapted property that is no longer required Current property in very poor condition (Please give details) Other (please give details)	<u>Details</u>
Have you completed a homeless application?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Don't know <input type="checkbox"/>	
Are you facing eviction or any court action in relation to your housing? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you ever been asked to leave, or have you ever been evicted from any previous accommodation? If	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have a local connection to the area? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have any pets/animals that you wish to be housed with you? If yes please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you need a property which is all on one level (i.e no stairs)? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Arrears and Debts	Details	
Have you been evicted or asked to leave any previous accommodation due to rent arrears? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you have any housing benefit arrears? If yes, please give details	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Do you have any outstanding debts, include rent arrears, fine, loans etc.? of yes, please give details		
Do you have a repayment plan?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other information		
Have you accessed supported Housing services in the past?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
If you have answered yes, please state where and when:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Have you ever been subjected to eviction proceedings?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
<i>Where you answer a yes to eviction please give overview and dates</i>		

Your financial situation			
Please tell us what benefits you currently claim/receive or have claimed (tick all that apply)	Employment support allowance <input type="checkbox"/>	Housing Benefit <input type="checkbox"/>	Disability allowance <input type="checkbox"/>
	Job seekers allowance <input type="checkbox"/>	Other	
	How much were you receiving?		
	When is the next sign on?		
	Which Job centre are you registered with? (if applicable)		
Are you currently working?	Yes	No	
If yes	Hours of work:		
	Weekly earnings:		

Your support needs			
Housing	Rent arrears		Reporting repairs
	Notice or evictions		Other:
Finance	Claiming benefits		Paying rent
	Paying bills		Other:
Personal Development	Training		Employment
	Education		Other:
Are you in school or taking a training course?		Yes	No
If yes	Course:		
	Hours per week:		
Do you have any pending loan?			
If yes, please can you give us more detail as this might affect your ability to claim certain benefits?			

Equal Opportunities Monitoring

Gender Male Female Prefer not to say

What is your ethnicity?

Ethnic origin is not about nationality, place of birth or citizenship. It is about the group to which you perceive you belong. Please tick the appropriate box

White

English Welsh Scottish Northern Irish Irish British
Gypsy or Irish Traveller Prefer not to say
Any other white background, please write in: _____

Mixed/multiple ethnic groups

White and Black Caribbean White and Black African White and Asian
Prefer not to say any other mixed background, please write in: _____

Asian/Asian British

Indian Pakistani Bangladeshi Chinese Prefer not to say Any other Asian background, please write in: _____

Black/ African/ Caribbean/ Black British

African Caribbean Prefer not to say
Any other Black/African/Caribbean background, please write in: _____

Other ethnic group

Arab Prefer not to say any other ethnic group, please write in: _____

Religion _____ Preferred Language _____

Disabilities

Sight impairment

Mobility

Hearing impairment

Mental Health

Physical disability

Progressive

Sexuality

Heterosexual

Homosexual

Bi-sexual

Lesbian

Other

Prefer not to say

Additional Information

These help us to better assess the client's suitability and ensure that the project is able to meet the individual's needs and provide appropriate support. Please indicate any such reports that you have attached.

Psychiatric	Yes	No
Risk Assessment	Yes	No
Care Plan	Yes	No
Forensic Report	Yes	No
Probation Report	Yes	No
Other (please state)	Yes	No

Please tick the relevant box if the client could be considered as presenting any risk to:

	High	Medium	Low
Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other clients accessing groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any significant others/members of the public	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you have ticked high or medium, please give details on the risk assessment sheet

RISK ASSESSMENT

This section of the form must be completed by the referring agency in order to help us identify the potential risks the client may pose to themselves, other service users and the staff team.

Section One	Not known	No	Yes (Details)
Harm to self			
Have you ever been at risk from others/aware of risk from others?			
Have you ever deliberately harmed yourself?			
Have you ever acted with suicidal intent or made any suicide attempt?			
Have you ever inflicted injury to yourself?			
Have you ever been affected by domestic abuse?			
Has your mental health deteriorated causing you distress and placing you at risk to self?			
Have you ever been seriously affected by the use of alcohol/illicit/ prescribed drugs that have caused you serious risk to self?			
Have you ever seriously neglected yourself? E.g. nutrition, hygiene, health or finance			

Section Two	Not known	No	Yes (Details)
Harm to others			
Have you ever in any way caused harm to others?			
Have you ever posed a risk to staff or volunteers, family or the general public?			

Have you ever been in a position of responsibility and neglected your duty?			
Have you ever been involved in incidents involving the police?			
Have you ever posed a driving risk to others?			
Has your mental health deteriorated causing you distress and placing you at risk to others?			
Have you ever been in a position of responsibility and neglected your duty?			
Have you ever seriously affected others due to the effects of alcohol/illicit/prescribed drugs?			

Section Three	Not known	No	Yes (Details)
Mental Health			
Does the client have a psychiatrist or other mental health worker?			
Does the client have a mental health diagnosis? Details if known			
Has the client ever spent time in a psychiatric ward?			
Is the client on any medication prescribed for mental health?			
Does the client have a history of mismanaging or abusing medication?			
Any other information about the clients mental health support needs and risk issues?			

Section Four	Not known	No	Yes (Details)
Addictions			
Does the client misuse illegal drugs?			

Does the client misuse alcohol			
Is the client recovering from any form of addiction			

Section Five	Not known	No	Yes (Details)
Criminal Activity			
Does the client have any criminal convictions?			
Is there a history of fire setting?			
Has the client served a custodial sentence?			
Is the client currently on probation or licence?			
Is the client likely to re-offend?			

Section Six	Not known	No	Yes (Details)
Support Network			
Is the client in regular contact with a supportive family?			
Is the client receiving agency support?			
Does the client have friends?			

Section Seven	Not known	No	Yes (Details)
Interpersonal Skills			
Does the client have a history or tendency towards aggression?			
Is the client capable of interacting with others?			
Is the client capable of adhering to conditions for accessing services?			

Please use this space to provide further details on the identified risks.

DO NOT COPY

How would individual access groups? (*i.e. travel independently, use bus, Community Transport etc.*)

Services Interested in Attending

Volunteering

Sporting
Changes

Creative
Crafts

Social
Drop-Ins

Befriending
Scheme

A Place to
Grow

Data Protection Act 1998 – the information you provide on this form will be available to members of staff at Community Action Partnership and in some situations with other relevant mental health professionals, in which case your permission will be sought first.

The information provided is given to the best of my knowledge. I will inform Community Action Partnership of any change in circumstances.

Signed (Client) Date:

Signed (Referrer) Date:

FOR OFFICE USE ONLY

Date referral received:	
Outcome of referral:	

DO NOT COPY