**Assessment Form**

|  |  |
| --- | --- |
| **Referral Agency** | **Date** |
|  |  |

|  |  |
| --- | --- |
| **Name** |   |
| **D.O.B** |  |
| **NI Number** |  |
| **Telephone Number** |  |
| **Gender** |  |
| **Marital Status** |  |
| **Ethnic Origin** |  |
| **Preferred Language** |  |
| **Probation Officer** |  |
| **Social Worker** |  |
| **C.P.N** |  |
| **Other Agencies** |  |

**Accommodation Details**

|  |  |
| --- | --- |
| **Local Connection** | **Yes No** |
| **If not, where from:** |  |

|  |
| --- |
| **How long has the client been homeless?** |

|  |
| --- |
| **Reason for homelessness?** |

|  |
| --- |
| **Where has the client been staying?** |

|  |
| --- |
| **Next of Kin****Name:****Address:****Tel No:****Relationship:** |

|  |
| --- |
| **If the client is estranged from family is reconciliation a possibility?** **Yes No****If you are able to, please give details:** |

|  |
| --- |
| **Does the client have any arrears from previous tenancies?****If yes, has a payment plan been set up, or are the arrears being paid off on a regular basis?** |

**Income Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **INCOME** **TYPE** | **WEEKLY AMOUNT** | **PROOF** **CONFIRMED** | **ADDITIONALCOMMENTS** |
| **JSA** |  |  |  |
| **ESA** |  |  |  |
| **Income Support** |  |  |  |
| **PIP/DLA** |  |  |  |
| **Incapacity Benefit** |  |  |  |
| **Training****Allowance** |  |  |  |
| **Housing Benefit** |  |  |  |
| **Salary** |  |  |  |
| **Other – please state** |  |  |  |

|  |
| --- |
| **Is Client submitting sickness certificates?** **Yes No****If yes, date last Cert submitted?** |

 **Physical Health Details**

|  |
| --- |
| **Does the client have any physical health/disability issues and/or on prescribed medication?** |

|  |
| --- |
| **Is the client registered with a G.P?****If yes, where and address/contact number** |

|  |
| --- |
| **Any Blood Born information:****e.g. Hep B/C, HIV** |

 **Mental Health Details**

|  |
| --- |
| **Does the client have any mental health issues and/or on any prescribed medication?****Details** |

|  |
| --- |
| **Is the client involved with Mental Health Services/CPN?****Details** |

 **Substance Misuse Details**

|  |
| --- |
| **Does the client have any issues with substance misuse/addiction?****Details** |

|  |
| --- |
| **Is the client involved with any Drug/Alcohol Services?****Details** |

 **Legal Details**

|  |
| --- |
| **Is the client on Bail, Supervision Order or due to appear in court?** **Yes No****Details** |

|  |
| --- |
| **Is the client registered with Probation?** **Yes No****Details** |

|  |
| --- |
| **Is the client currently on a hospital ward, prison or rehab unit?** **Yes No****Planned discharge or release date?** |

|  |
| --- |
| **Has the client ever been convicted of:****A serious violent offence****A arson offence****A sexual offence****If yes to any of the above, please provide details including dates of conviction:** |

**Risk Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name:** |  | **D.O.B.** |  |

**Section A - Risk of Harm to Others (Violence & Abuse)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk** | **Yes** | **No** | **Don’t Know** |
| Current behaviour/demeanour is threatening or abusive |  |  |  |
| Previous incidents of violence or physical aggression |  |  |  |
| Expressing intent to harm others |  |  |  |
| Conviction or arrest for violent behaviour |  |  |  |
| Previous history of sexual offending or sexually inappropriate behaviour  |  |  |  |
| Close associates known to be aggressive |  |  |  |

**Section B – Risk of Self-Harm**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk** | **Yes** | **No** | **Don’t Know** |
| Current or previous self-harming behaviour |  |  |  |
| Current or previous suicidal thoughts |  |  |  |
| Recent significant life events |  |  |  |
| Alcohol misuse |  |  |  |
| Drug misuse |  |  |  |
| Poor engagement with services/concern expressed by others |  |  |  |

**Section C – Risk of Damage to Property**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk** | **Yes** | **No** | **Don’t Know** |
| History of arson |  |  |  |
| History of vandalism or damage to buildings |  |  |  |

 **Section D – Risk of Self-Neglect/Vulnerability to Abuse**

|  |  |  |  |
| --- | --- | --- | --- |
| **Risk** | **Yes** | **No** | **Don’t Know** |
| Failure to eat/drink properly |  |  |  |
| Poor personal hygiene |  |  |  |
| Inappropriate clothing |  |  |  |
| Evidence of failure to seek medical attention for ill health |  |  |  |
| Financial difficulties in meeting basic needs |  |  |  |
| Learning difficulties/disabilities or other inability to express needs |  |  |  |
| Poor awareness of personal safety |  |  |  |
| Poor ability to look after cleanliness and safety of home |  |  |  |
| Previously subjected to violence/harassment from others |  |  |  |

**If you answered Yes to any of the above Sections, please provide further details below:**

|  |  |
| --- | --- |
| **Section** | **Details** |
|  |  |

**DECLARATION**

**Date:**

**Signature of Person Completing Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name** |  | **Agency** |  | **Signature** |  |

**Signature of Client (if applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Signature** |  |

**Interagency Consent to Share**

It has been explained to me that information about me such as health, welfare and housing needs may need to be shared between different agencies in order to help The Solace Community to assess my suitability.

I understand that any information divulged will not be shared outside the authorised organisations, unless there is an identified risk to yourself, others or property.

I give the services below permission to exchange information with The Solace Community relating to my housing and support needs:

**DWP/Housing Benefit Agency**

**GP/Health Services**

**Mental Health Services**

**Drug & Alcohol Agencies**

**Probation Services**

**Social Services**

**Local Authority Housing Department**

**Other (please specify)…………………………………………………………………….**

**Name:**

**Signature:**

**Date:**

**FOR COMPLETION BY SOLACE COMMUNITY STAFF**

**Name of Applicant:**

**Based on the information available, confirm the level of Support Needs & Risks identified:**

**Scale 1= Low, 5 = High**

|  |  |  |
| --- | --- | --- |
| **NEEDS** | **SCALE** | **COMMENTS** |
| Affordability |  |  |
| Physical Health |  |  |
| Mental Health |  |  |
| Legal |  |  |
| **RISKS** |  |  |
| Self Harm |  |  |
| Risk to Others |  |  |
| Risk From Others |  |  |
| Social Risks |  |  |

**Can the Solace Community accommodate this applicant?**

|  |
| --- |
|  |

**YES**

|  |
| --- |
|  |

**NO**

**If declined, state reasons why and recommendations to meet the applicants needs in the box below:**

|  |
| --- |
|  |

**Completed By:**

**Date:**