**Referral/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** |  |
| **Recovery near you**  |  |
| **Other Agencies** |  |

**Accommodation Details**

|  |  |
| --- | --- |
| **Local Connection** |  |
| **If not, where from:** |  |

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

|  |
| --- |
| **Reason for homeless? / Where has the client been staying ?** |

|  |
| --- |
| **Has the client ever had Covid 19 / TB or any other notifiable disease ?** |
| **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** | **ADDITIONAL COMMENTS** |
| **JSA** |  |  |  |
| **ESA** |  |  |  |
| **Income Support** |  |  |  |
| **PIP/DLA** |  |  |  |
| **Incapacity Benefit** |  |  |  |
| **Universal Credit** |  |  |  |
| **Housing Benefit** |  |  |  |
| **Salary** |  |  |  |
| **Other – Please state** |  |  |  |

|  |
| --- |
| **Provisional offer of a bed space:****Name.............................. you are being given a bed space on the understanding that you will show proof of benefit or make a claim for universal credit within 72 hours.** **If you need any assistance with this a member of the project staff will go through the process with you.** **If you do not fulfil this obligation, then The Solace Community will have no alternative but to close your bed space forthwith.** **Is client submitting sickness certificates?** **Yes No****If yes, date last certificate submitted?** |

**Physical Health Details**

|  |
| --- |
| **Does the client have any physical health/disability issues and/or on prescribed medication?****Any Allergies medical or food related?** |

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

|  |
| --- |
| **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?** |

**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****An 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** |  | **Agency** |  | **Signature** |  |

**Interagency consent to share**

It has been explained to me that information about me such as health, welfare and housing needs may 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 (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)Surgery**

**Mental Health Services**

**Drug & Alcohol Services**

**Probation Services**

**Social Services**

**Local Authority Housing Department**

**Other (Please Specify)………………………………………………..**

**Name:**

**Signature:**

**Date:**