TEAM A5 SUPPORT
TRANSFORMING LIVES

# Team A5 Support

## Supported Housing Referral form

**This referral form is an indicator of the housing need and Risk issues. It does not replace a thorough assessment. A referral to Team A5 support does not guarantee acceptance.**

Referral forms submitted without supporting evidence or in depth information relating to the need and risk will be delayed where there are serious issues highlighted.

## Part 1 Referee Personal Details

Full Name: ______________________________

*Last* *First* *M.I.* Date of Birth: Age

National Insurance Number

Address: ______________________________

*Street Address* *Flat #*

______________________________

*City* *County* *Post Code*

***Is the Address provided above one of the following:***

*Temporary Accommodation provided by the council ☐, Council Property☐, Own tenancy/ privately rented☐, Friends/Family member's address☐, Client is sofa surfing ☐*

Gender **Male** Female ☐ **Transgender** ✗

Phone: ______________ Email ______________

## 2. NEXT OF KIN DETAILS

First Name ______________________________

Surname

Address

Relationship

Telephone Number ______________________________

## 3. CLIENT GROUP/VULNERABILITY

**Please tick all the boxes that apply to your client vulnerabilities. You will be asked for further information about any of the vulnerabilities identified in this application**

Mental Health needs
Drug Dependency
Alcohol Dependency
Single Homeless with Support Needs
Elderly

Offender
Rough Sleeping
Learning Disability
HIV/AIDS
Other

## 4. REFERRAL AGENCY DETAILS

Referrer Name ______________________________

Relationship to Client
Length of Time client has been known to you
Organization name and address
Telephone Number **Landline:** **Mobile Number:**
Email Address

5/ Current Support Provision

| Does the tenant have an actual or potential need for Care, Support or Supervision? | If Yes, please summarise the reasons for their need. |
|---|---|

**Please describe the nature of Support currently provided by your organisation. This information should include how often your client engages with you and what that support entails.**

## 6/ Housing History

**Please provide details of the clients housing history over the last 5 years. This information should include details of any time spent in hospital, prison or periods of rough sleeping.**
**Please also indicate why each of the tenancies in the previous 5 years broke down or ended.**

Reasons for previous tenancy breakdowns may include:
Rent arrears/ Anti-social behaviour / Noise nuisance /hospital admission / period in custody / relationship breakdown /escaping violence /mobility issues /abandonment /sofa surfing /overcrowding /inability to cope etc.

**Address** From To
Reason for leaving/tenancy end

**Address** From To

Reason for Leaving/tenancy

Address From To

Reason for Leaving/tenancy

Address From To

Reason for Leaving/tenancy

Address From To

Reason for Leaving/tenancy

## 7/ Type of Support Required

**Please indicate the type of support your client will require**

| | |
|---|---|
| Requires access to support on site for most of the time i.e. 24 hours a day | ☐ |
| May require support more intensively when in crisis but could manage with support provided during office hours. | ☐ |
| Can Manage with visiting support provided once or twice weekly | ☐ |

## 8/BENEFITS

Please indicate if the client is in receipt of benefits from the department of Works and Pensions (DWP) or an alternative source

| | | | |
|---|---|---|---|
| Income Support | ☐ | Jobseekers Allowance | ☐ |
| Incapacity Benefit | ☐ | Disability Living Allowance | ☐ |
| State Pension | ☐ | Salary/ Wages | ☐ |
| Currently not in receipt of benefits | ☐ | Have applied for benefits but not in receipt yet. | ☐ |
| Other | ☐ | Please specify: | ☐ |

## 9/ MENTAL HEALTH NEEDS

| | | | |
|---|---|---|---|
| **Please state the clients Mental Health Diagnosis** | | | |
| **Please tick the box that applies to your client.** | | | |
| Depression | ☐ | CPA standard Level | ☐ |
| Suicidal Ideation | ☐ | CPA enhanced Level | ☐ |
| Receiving Outpatient treatment | ☐ | Schizophrenia | ☐ |
| Panic/Anxiety attacks | ☐ | Personality Disorder | ☐ |
| Supported by forensic mental health team | ☐ | | |
| **If the client has an allocated Care Co-ordinator, please provide their details below** | | | |
| Name | | | |
| Telephone Number | | | |
| Email Address | | | |

## 10/ OFFENDER SPECIFIC INFORMATION

| | | |
|---|---|---|
| Is your client still in prison? | **Yes** ☐ | No ☐ |
| **If there is a prison contact worker, please provide the details below.** | | |
| Name | | |
| Telephone Number | | |
| Email Address | | |
| If your client is still in custody, please state the earliest possible release date. | | |
| Are there any further pending court cases? | **Yes** ☐ | No ☐ |
| **If you have indicated yes, please provide details e.g. dates below and the reason for the pending court case.** | | |
| | | |
| **Is a custodial sentence likely because of a pending court case?** | **Yes**☐ | **No** ☐ |

| | | | |
|---|---|---|---|
| **Type of License** <br> **Please tick the box that may apply to your client.** | | | |
| **None** | ☐ | **Community Order** | ☐ |
| **MAPPA (please state what level)** | ☐ | **IOM** | ☐ |
| **Antisocial Behaviour Order** | ☐ | **DRR** | ☐ |

| **Life License** | ☐ | | ☐ |
|---|---|---|---|
| **Schedule 1- offender** | ☐ | **Has the offender been requested to notify the police of his/her address in accordance with part 1 of the sex Offenders Act?** | ☐ |
| **Other type of license. Please specify** | | | |
| **License End date** | | | |
| **Please state the conditions of the license your client is subject to and if there are any placement issues relating to risk e.g. location of victim or community links** | | | |
| If the offender is subject to a tag, please state the conditions of the tag. | | | |
| If the offender is subject to an ASBO , please state the conditions of the ASBO. | | | |
| **Please detail any programmes attended and completed whilst in custody/supervision** | | | |
| | | | |

| **If the offender has an allocated Offender Manager (Probation Service), please provide their details below.** | |
|---|---|
| **Name** | |
| **Telephone number** | |
| **Email Address** | |

| For Offender Managers only<br><br>Please provide the Risk of Harm Summary from the Oasys report.<br>Please provide a summary of offender's previous offences as described on the first page of the MG16 |
|---|
| The description of the offence should describe:<br>1/ the nature and frequency of the offending behaviour<br>2/ the background of the offending behaviour<br>3/an assessment of the risk of the behaviour manifested against the housing provider/staff, other clients and equipment |

11/ SUBSTANCE DEPENDENCY

| Please tick the boxes that may apply to your client. | | | |
|---|---|---|---|
| Drug dependent | ☐ | Alcohol dependent | ☐ |
| On a methadone programme | ☐ | On a subtext script | ☐ |
| **Level of use.** Please state **how much** your client | | | |
| **Pattern of use.** Please **describe** your clients pattern of consumption. This may include binge use or regular use or around a particular time etc. | | | |

| **Completed a Detox** | ☐ | Dates of Detox | **From** | **To** |
|---|---|---|---|---|
| | | | | |

| **Completed a rehab** | ☐ | Dates of rehab | | |
|---|---|---|---|---|
| Type of Drug dependency. Tick the boxes that may apply to your client | | | | |
| Heroin | ☐ | Crack | ☐ | |
| Cocaine | ☐ | Cannabis | ☐ | |
| Amphetamines | ☐ | Tranquillizers | ☐ | |
| Methadone | ☐ | KHAT | ☐ | |
| Ketamine | ☐ | | ☐ | |
| **Other. Please specify** | | | | |

12/ YOUNG PERSON

| Is the young person estranged from their family | Yes | ☐ | No | ☐ |
|---|---|---|---|---|

| **Please tick the boxes that apply to your client** | | | |
|---|---|---|---|
| Young person below 18 | | | |
| Young person leaving care | | | |
| Young preson engaging with CAMHS | | | |
| **If your client is a teenage parent, please provide their details.** | | Name | |
| | | Date of Birth | |
| **If your client is engaging with a young people's service, please provide their contact details below** | | | |
| Name | | | |
| Telephone Number | | | |
| Email Address | | | |

13/ OTHER SUPPORT SERVICES

| Please indicate if the applicant receives support from any other service such as a social worker, drug services, probation, councilor, GP. Please provide contact details | | |
|---|---|---|
| Name | Telephone | Email |
| | | |
| | | |

14/ ADDITIONAL COMMENTS AND INFORMATION

| Please indicate the type of support that would benefit your client | | | |
|---|---|---|---|
| Budgeting | ☐ | Personal hygiene | ☐ |
| Debt Management | ☐ | Maximizing benefits | ☐ |
| Literacy/numeracy support | ☐ | Social isolation | ☐ |
| Links to community services | ☐ | Links to local health services | ☐ |
| Accessing education/employment | ☐ | Cooking | ☐ |
| Assistant with taking medication | ☐ | | |
| Other. Please elaborate if you feel your client needs help in any other areas. | | | |

15/SUPPORTING DOCUMENTS CHECKLIST

| **Please indicate which document you are providing in addition to this referral form** | |
|---|---|
| Summary of previous convictions | |
| Risk of harm summary | |
| Psychiatric report | |
| Care Programme Approach community care plan | |
| Social Services Fulll Risk Assessment | |
| Asset report ( Serious risk of harm). | |
| Early intervention service report | |

| PULSE report | |
|---|---|
| ILDP Community Care Assessment Summary | |
| Other. Please specify | |

16/DECLARATION

| Please sign below to show that the information given is accurate and to confirm that you have given Team A5 Support the consent to share your information with individuals who support you.<br>By providing your consent, you are also agreeing to allow Team A5 Support to contact relevant agencies to corroborate your information. | |
|---|---|
| Applicant Signature | |
| Date | |
| Witnessed by | |
| Date | |
| Please print name | |
| Position/Job title | |

## Information sharing

*(For Offender Managers Only)*

| *INFORMATION EXCHANGE BETWEEN PROBATION AND HOUSING PROVIDERS*<br>*Please ensure that the section below is completed if you are sending this referral via the probation service.*<br>*Please ensure that the consent form on the last page of this referral has been signed.*<br>*Please also explain to your client the nature of the information being shared and with whom.* |
|---|
| *In order for housing agencies and local authorities to find out if they can meet your needs, and provide appropriate housing and or services, they need to know about your housing and offending histories and any risk of harm you may pose to either yourself or other people.*<br>*All relevant information about you, which is passed between London Probation, and other criminal justice systems, charities etc and Team A5 support will be kept confidential unless there is a serious risk of harm involved and the appropriate agencies then need to be contacted.*<br>*If you are not willing for London Probation to share information about you with Team A5 support we will not be able to progress with your referral.* |

| *I consent to information about my housing history and offending, OASys, and my risk of harm assessment being exchanged with the local authority and housing providers* | |
|---|---|
| *Signed* | |
| *Date* | |
| *Please print Name* | |

## Disclaimer and Signature

*I certify that my answers are true and complete to the best of my knowledge.*

*If this application leads to an offer , I understand that false or misleading information in my application or interview may result in my release/ termination of notice.*

Signature: ______________________________ Date:____________________

Equal Opportunity Monitoring
We keep records of the ethnic origin of anyone who applies to us for support. This is to ensure that our service is provided on an equal basis

**EQUAL OPPORTUNITIES**
We aim to promote equality and inclusion to ensure fair access to the service in line with the Equalities Act 2010. These questions are used to monitor access to the service and are not used to make decisions on eligibility or allocation. We will not discriminate unlawfully and our Equality Protocol is available on request.

| **Ethnicity** | |
|---|---|
| **Asian**<br>☐ ☐ Bangladeshi Pakistani<br>☐ Indian ☐ Other | **Black**<br>☐ African<br>☐ Caribbean |
| **Chinese or other ethnic group**<br>☐ Chinese<br>☐ Other | **Gypsy and Traveller**<br>☐ Gypsy ☐ Irish Traveller<br>☐ Other |
| **Mixed**<br>☐ White and Black ☐ Carib White and<br>☐ Black Afr ☐<br>White and Asian White and Other | **White**<br>☐ White British ☐ Eastern European<br>☐ White Irish ☐ White Other |
| ☐ Prefer not to say | ☐ Not known |
| **Religion/ Belief** | |
| ☐ Christian<br>☐ Muslim<br>☐ Hindu<br>☐ Jewish<br>☐ Sikh | ☐ Buddhist<br>☐ Other<br>☐ Atheist<br>☐ Agnostic<br>☐ Prefer not to say ☐ Not known |
| **Marital/Civil Partnership Status** | |
| ☐ Married Not known | ☐ Civil Partnership |

| | |
|---|---|
| ☐ Single<br>☐ Divorced<br>☐ Widowed<br>☐ Prefer not to say ☐ | ☐ Dissolved Civil Partnership<br>☐ Separated<br>☐ Other<br>☐ Prefer not to say ☐ Not known |
| **Gender** | **Sexuality** |
| ☐ Male<br>☐ Female<br>☐ Transgender<br>☐ Other<br>☐ Prefer not to say<br>☐ Not known | ☐ Heterosexual<br>☐ Gay<br>☐ Lesbian<br>☐ Bisexual<br>☐ Other<br>☐ Prefer not to say ☐ Not known |
| **Pregnant or given birth in the last 6 months?** | ☐ ☐ ☐ Yes No Prefer not to s☐ |
| **Disability** | ☐ ☐ ☐ Yes No Prefer not to s☐ |
| A person is disabled under the Equality Act 2010 if they have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. | |

Appendix A

**For use with Substance Misuse Referrals Only**

| SUBSTANCE | Past use at height (per day) | Time since most recent use & level of use | Route | Age first used | Most problematic (as seen by applicant) |
|---|---|---|---|---|---|
| ALCOHOL | | | | | |
| AMPHETAMINES | | | | | |
| BENZODIAZAPINES | | | | | |
| CANNABIS | | | | | |
| COCAINE | | | | | |
| CRACK | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| DF118s | | | | | |
| ECSTASY | | | | | |
| HEROIN | | | | | |
| KETAMINE | | | | | |
| LSD | | | | | |
| METHADONE | | | | | |
| MUSHROOMS | | | | | |
| STEROIDS | | | | | |
| SOLVENTS | | | | | |
| TEMGESICS | | | | | |
| OTHER | | | | | |

Person to contact in emergency
Address

Tel No

GP Name Tel No.

Consultant Name Tel No.

**Other Agency Contacts**

Contact Agency Tel No.

Contact Agency Tel No.

**PREVIOUS HOSPITAL ADMISSIONS**

**REFERRAL DECISION MEETING**

COMMUNITY FLOATING SUPPORT Accepted ☐ Not Accepted ☐

Date Accepted
Reasons for Non-acceptance

Date of Referral:
Referring Officer: Designation:

Full details of the individual(s) must be provided in the section below.

| **DETAILS OF THE INDIVIDUAL(S)** | **(Full particulars required)** |
|---|---|

| | |
|---|---|
| **Full Name** | |
| **Date and Place of Birth** | |
| **Current/Previous Address** | |
| **Alias / Maiden Name(s)** | |

| **Any other Information:** |
|---|
| |
| |
| |

**INFORMATION REQUESTED** **(Delete as appropriate)**

- Details of any criminal convictions / cautions involving relevant activities
- Details of recent recorded information which would indicate they are likely to have a negative impact on crime and antisocial behaviour in the Durham area or pose a threat to staff and other residents.

Signed: ________________________________________ Date: __________

***Convictions and Cautions will only be deemed relevant if:***

***The applicant has been convicted or cautioned for***

- ***Arson***
- ***Any Sexual Offence***
- ***Violence***
- ***Drugs***
- ***Any other offence in the last 3 years which would indicate that the housing of the subject is likely to have an impact on crime and anti-social behaviour in the Durham area or pose a threat to the safety of staff and/or other residents.***

**NB: Offences, which are spent under the Rehabilitation of Offenders Act 1974 and cautions/convictions relating to Juveniles, will NOT be disclosed.**

**Only minimum relevant information to achieve the purpose will be disclosed.**

**A SIGNED COPY OF APPLICANTS CONSENT FOR POLICE DISCLOSURE MUST BE ATTACHED IN ALL CASES**

**RISK ASSESSMENT** **NB: This Section MUST be completed**

**Please use the following definitions to answer the questions:**

| | |
|---|---|
| **LOW** | Isolated or occasional instances of non-significant incidents and/or a low potential of incidents occurring or recurring. |
| **MEDIUM** | More frequent/regular incidents and/or of a more significant nature |
| **HIGH** | Likely, severe or significant |

| Category | L | M | H | Comments |
|---|---|---|---|---|
| **Does the applicant have a history/is there a risk of any of the following violent offences/incidents *to* others:** | | | | |
| Physical abuse | ☐ | ☐ | ☐ | Describe below potential triggers and who is at risk: |
| Mental abuse | ☐ | ☐ | ☐ | |
| Sexual abuse | ☐ | ☐ | ☐ | |
| Racial abuse | ☐ | ☐ | ☐ | |
| Verbal abuse | ☐ | ☐ | ☐ | |
| Damage to property/arson | ☐ | ☐ | ☐ | |
| **Is there a history of difficulties regarding previous tenancies?** | | | | |
| Rent arrears | ☐ | ☐ | ☐ | If any identified, please give further details: |
| Behaviour of friends | ☐ | ☐ | ☐ | |
| Neighbour disputes | ☐ | ☐ | ☐ | |
| Anti-social behaviour | ☐ | ☐ | ☐ | |
| Evictions | ☐ | ☐ | ☐ | |
| Harassment | ☐ | ☐ | ☐ | |
| Other | ☐ | ☐ | ☐ | |
| **Is there a history of or risk from others/client's vulnerability of any of the following?** | | | | |
| Suicide | ☐ | ☐ | ☐ | If any identified, please give further information including triggers, details of incidents etc: |
| Self-harm | ☐ | ☐ | ☐ | |

| | | | | |
|---|---|---|---|---|
| Accidental overdose | ☐ | ☐ | ☐ | |
| Misuse/non-compliance of medication | ☐ | ☐ | ☐ | |
| Abuse from others | ☐ | ☐ | ☐ | |
| Vulnerability | ☐ | ☐ | ☐ | |
| Mental health issues/Depression | ☐ | ☐ | ☐ | |
| Substance misuse (Drugs and Alcohol) | ☐ | ☐ | ☐ | |
| Physical Health/Disability | ☐ | ☐ | ☐ | |
| Learning Disability | ☐ | ☐ | ☐ | |

**If you are a referral agency, please state how long you have known the Applicant?**

**Is it safe to visit the Applicant at home? Yes** ☐ ☐
**No** If no, where is there another safe place?

**Has the Applicant ever been refused support? Yes** ☐ ☐
**No** If yes, please state why?

**Please provide any other relevant information:**

**AUTHORISATION**

| I confirm that the information contained in this document is true and includes all relevant information required to correctly assess this referral. | | | |
|---|---|---|---|
| Signed: *(Applicant)* | | Date: | |
| Signed: *(Referral Agency)* | | Date: | |
| If obtaining a signature was not possible, tick to confirm you have the Applicant's verbal authorisation: ☐ | | | |

**CONSENT**

| *Under the Data Protection Act 1998 it is a requirement to obtain your consent to share information about you with other agencies and organisations who may be involved in providing services to you. You have a right to prevent this and therefore do not have to consent if you do not want your information to be shared. However, it may be difficult to provide you with some of the services you need if you do not give your consent.*<br><br>In order to ensure the correct level of support is offered, and to safeguard the needs of all individuals we may need to obtain further information relevant to your application.<br><br>I give my permission for agencies to obtain further information from all other relevant agencies which may include, for example, Adult and Community Services, landlords, police, probation, benefits agencies and housing benefit offices.<br><br>I understand that this information will only be made available to all providers/organisations that are able to assist me to obtain the correct level of support and enable me to sustain independent accommodation. | | | |
|---|---|---|---|
| Signed: *(Applicant)* | | Date: | |
| If obtaining a signature was not possible, tick to confirm you have the Applicant's verbal consent: ☐ | | | |