TEAM A5 SUPPORT
TRANSFORMING LIVES

792-794 London Road, Thornton Heath,
Croydon CR7 6JB. Tel: 02086867297

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: *first* _____ *last* _____	**Date of Birth:** _____
National Insurance Number: _____	**Age:** _____

Street Address: _____ **Flat:** _____

City: _____	**County:** _____	**Post Code:** _____

Is the Address provided above one of the following (mark X):

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:* ☐		
Email:	_____	Phone:	_____

PART 2: NEXT OF KIN DETAILS

First Name	
Surname	
Address	
Relationship	
Telephone Number	

PART 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	☐	Offender	☐
Drug Dependency	☐	Rough Sleeping	☐
Alcohol Dependency	☐	Learning Disability	☐
Single Homeless with Support Needs	☐	HIV/AIDS	☐
Elderly	☐	Other	☐

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PART 4: REFERRAL AGENCY DETAILS		
Referrer Name:		
Relationship to Client:		
Length of time client has been known to you:		
Organization name & Address:		
Telephone Number:	*Landline:*	*Mobile:*
Email Address:		

PART 5: CURRENT SUPPORT PROVISION	
Does the tenant have an actual or potential need for Care, Support or Supervision?	If **YES**, please summarize the reasons for their need.

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

PART 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
1.			

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2.				
3.				
4.				
5.				

PART 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	

PART 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:	

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PART 9: MENTAL HEALTH NEEDS			
Please state the clients Mental Health Diagnosis			
Please tick or mark (X) in 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		Others, please specify	

If the client has an allocated Care Co-Ordinator, please provide their details below	
Name	
Telephone Number	
Email Address	

PART 10: OFFENDER SPECIFIC INFORMATION.		
Is your client still in prison? (Tick or mark X)	**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? (Tick or mark X)	**Yes**	**No**

If you have indicated yes, please provide details example: dates below and the reason for the pending court case.

State your reasons here:

Is a custodial sentence likely because of a pending court case?	**Yes**	**No**

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Type of License

Please tick or mark X in the box that may apply to your client.

None		**Community Order**	
MAPPA (please state what level)		**IOM**	
Antisocial Behavior 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 types of licenses. 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 programs 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

> Please provide the Risk of Harm Summary from the OASys report.
> Please provide a summary of the offender's previous offences as described on the first page of MG16.

The description of the offence should describe:

1) ***The nature and frequency of the offending behaviour***
2) ***The background of the offending behaviour***
3) ***An assessment of the risk of the behaviour manifested against the housing provider/staff, otherclients, and equipment.***

State your reasons here:

PART 11: SUBSTANCE DEPENDENCY

Please tick or mark X in 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 uses				
Pattern of use. Please **describe** your client's 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	*From*	*To*

Type of Drug dependency. Tick the boxes that may apply to your client			
Heroin		**Crack**	
Cocaine		**Cannabis**	
Amphetamines		**Tranquillizers**	
Methadone		**KHAT**	
Ketamine		**Others**	
If **Other**, please specify:			

PART 12: YOUNG PERSON

Is the young person estranged from their family (tick or mark X)	**Yes**	**No**

Please tick or mark X in the boxes that apply to your client		
Young person **below 18**		
Young person **leaving care**		
Young person **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	

PART 13: OTHER SUPPORT SERVICES

Please indicate if the applicant receives support from any other service such as a social worker, drug services, probation, counsellor, GP. Please provide contact details

Name	Telephone	Email

PART 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.
State your reasons below here:

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PART 15: SUPPORTING DOCUMENTS

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 Full Risk Assessment	
Asset report (Serious risk of harm).	
Early intervention service report	
PULSE report	
ILDP Community Care Assessment Summary	
Other. Please specify	

PART 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. By providing your consent, you are also agreeing to allow Team A5 Support to contact relevant agencies to corroborate your information.

Applicant Signature:	*Sign here:*
Date:	
Witnessed by	
Date:	
Please print name:	
Position/Job title:	

INFORMATION SHARING

(For Offender Managers Only)

INFORMATION EXCHANGE BETWEEN PROBATION AND HOUSING PROVIDERS

- *Please ensure that the section below is completed if you are sending this referral via the probation service.*
- *Please ensure that the consent form on the last page of this referral has been signed.*
- *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.

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.

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:**	

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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

Please tick or mark X in the box below

Asian Bangladeshi ☐ Pakistani ☐ Indian ☐ Other ☐	**Black** African ☐ Caribbean ☐
Chinese or Other ethnic group Chinese ☐ Other ☐	**Gypsy and Traveler** Gypsy ☐ Irish Traveler ☐ Other ☐
Mixed White and Black ☐ White and Asian ☐ Carib White & Black Afr. ☐ White and Other ☐	**White** White British ☐ Eastern European ☐ White Irish ☐ White Other ☐
Prefer not to say ☐	Not known ☐

RELIGION/BELIEF					
Christian ☐	Muslim ☐	Hindu ☐	Buddhist ☐	Sikh ☐	Jewish ☐
Other, please specify		Atheist ☐	Agnostic ☐	Prefer not to say ☐	Not Known ☐

MARITAL/CIVIL PARTNERSHIP STATUS					
Married ☐	Single ☐	Divorced ☐	Widowed ☐	Civil Partnership ☐	Separated ☐
Dissolved Civil Partnership ☐		Other ☐	Prefer not to say ☐	Not Known ☐	

GENDER					
Male ☐	Female ☐	Transgender ☐	Other ☐	Prefer Not to Say ☐	Not Known ☐

SEXUALITY						
Heterosexual ☐	Gay ☐	Lesbian ☐	Bisexual ☐	Other ☐	Not Known ☐	Prefer Not to Say ☐

Pregnant or given birth in the last6 months?	Yes ☐	No ☐	Prefer Not to say. ☐	Not Known ☐
Disability	☐	☐	☐	☐
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.				

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For use with Substance Misuse Referrals Only

Appendix A

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					
BENZODIAZEPINES					
CANNABIS					
COCAINE					
CRACK					
DF118s					
ECSTASY					
HEROIN					
KETAMINE					
LSD					
METHADONE					
MUSHROOMS					
STEROIDS					
SOLVENTS					
TAGMEMICS					
OTHER					

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For use with AC&S Community Mental Health Floating Support Service Only

Appendix B

Person to contact in emergency	
Name	
Address	
Phone number	
GP Name	
Consultant Name	

Other Agency Contacts			
Agency Name:		Telephone:	
Agency Name:		Telephone:	

Previous Hospital Admissions

Referral Decision Meeting		
Community Floating Support	Accepted ☐	Not Accepted ☐
Date Accepted		

Please state reasons below if not accepted:

Referring Officer:	
Date of Referral:	
Designation:	

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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 INFORMATIONS

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 behavior 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 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

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Please use the following definitions to answer the questions:

RISK ASSESSMENT - NB: THIS SECTION MUST BE COMPLETED.	
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:
Behavior of friends	☐	☐	☐	
Neighbor disputes	☐	☐	☐	
Anti-social behavior	☐	☐	☐	
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?

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Please provide any other relevant information:

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 authorization: ☐

CONSENT

Under the Data Protection Act 1998 it is a requirement to obtain your consent to share information about you with other agencies and organizations 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.

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.

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.

I understand that this information will only be made available to all providers/organizations 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 or mark X to confirm you have the Applicant's verbal consent: ☐