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| **Sandwell Floating Support Service**  **Referral Form** | H:\share\Logo's\new_smbc_logo.jpg |

Sandwell’s Floating Support Service provides housing-related support to vulnerable people to either remain in their homes and maintain their independence or resettle back into the community and become independent. The support we offer is designed to help people develop the skills they need to run a home, stay safe, be healthy, and as well as participating in work, volunteering or social activities that make them feel part of their local community. The support we provide will be different for each person as it is designed to specifically meet that person’s individual need.

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| **Privacy Notice**  To understand more about why we collect your information, what we do with your information, how you can access your information, your personal information rights, how and to whom to raise a complaint about your information, please visit our privacy notice page at <http://www.sandwell.gov.uk/privacynotices> |

**Are you eligible for the service - please tick all that apply.**

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|  | You must be either resident in Sandwell or placed out of borough in temporary accommodation by the Housing Options service or Sandwell MBC. |
|  | You must have recourse to public funds. |
|  | You should be aged 18 or over (there is no upper age limit). |
|  | Young people aged between 16 and 17 will be considered who have been granted an independent tenancy or home and need support to sustain their accommodation. |

**Referral**Please ensure **ALL** sections of this form are completed to prevent any delay in the processing of your referral.

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| **REFERRAL DETAILS** | | | |
| **Client Name** |  | | |
| **Client Date of Birth** |  | | |
| **Client Address** |  | | |
| **Client Telephone number** |  | | |
| **Client NHS Number** |  | | |
| **Client Ethnicity** |  | | |
| **Client Religion** |  | | |
| **1st Language:** |  | **Interpreter needed** | **Y/N** |
| **Referral Date** |  | | |
| **Capacity:** Do you have capacity to make informed decisions about your own well-being?  Tick as appropriate: Yes 🞏 No 🞏 Don’t know 🞏 | | | |
| **Do you want us to liaise with anyone else on your behalf if we need to arrange an assessment?**  Tick as appropriate: Yes 🞏 No 🞏  If yes, please provide the person’s contact name and telephone number below: | | | |
| **Are there any risks that we should be aware of?**  Tick as appropriate: Yes 🞏 No 🞏  If yes, please tell us more below: | | | |

Please tick yes or no to the statement that applies to you; **if you don’t answer these questions we will not be able to accept your referral.**

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| **CRITERIA** | **Yes** | **No** |
| 1. I am homeless and have been placed in temporary accommodation by the Local Authority |  |  |
| 1. I am homeless and have been awarded a priority by the Local Authority for housing and need support to re-settle |  |  |
| 1. I am at risk of homelessness (for example I am not managing in my current home and at risk of losing the place I currently live in) |  |  |
| 1. I would not be able to move in to more independent accommodation without support (for example I am moving from supported or semi supported housing or I am an offender leaving prison and need help to resettle) |  |  |
| 1. I am at significant risk of harm (for example safeguarding, domestic abuse, harassment due to vulnerability, race or culture) |  |  |
| 1. I need support following discharge from hospital (for example to enable me to re-settle back into my home and have no family, friends or support to help me) |  |  |
| 1. I need support to prevent the risk of admission to hospital or similar (with appropriate support I can remain at home and receive treatment and I have no family, friends or other support to help me) |  |  |

If none of the above statements apply to you then we will not be able to consider you for the Floating Support Service.

If you have answered **YES** to any of the above statements, please continue to tell us a bit more about your situation.

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| **Please tick to indicate which particular area is making you feel vulnerable at the moment:** | |
|  | Mental health |
|  | Physical health |
|  | Learning disability |
|  | Substance misuse |
|  | Homeless |
|  | Leaving care |
|  | Domestic abuse |
|  | Family with children who are at risk of higher intervention (Children’s services involvement/youth offending) |

Please tell us what outcome you want to achieve to maintain your own well-being: if we accept your referral for assessment we will discuss this in more detail at your face to face interview.

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| **Outcome** | **Yes** | **No** |
| 1. To support me to establish and maintain a successful tenancy due to Homelessness |  |  |
| 1. To support me to establish and maintain a successful tenancy as I am at risk of becoming homeless |  |  |
| 1. To assist me to resettle into more suitable accommodation |  |  |
| 1. I require support from risk of harm |  |  |
| 1. I require support to assist with my discharge from hospital as I have no family support/network |  |  |
| 1. I require support with my physical and mental wellbeing to prevent my condition deteriorating and the impact this may have |  |  |

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| Please give us further information regarding your current circumstances and need for support**:** | | | | |
| **Authority to Act on Behalf of and request information:**  Finally, please confirm that you authorise the Floating Support Service to contact and request information and to act on your behalf with agencies and authorities as necessary | | | | |
| Signed |  | Date |  |  |
| **In addition to the above, please complete below if you have completed this referral on behalf of the client:**  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Contact Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Profession \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

When complete please return to [Floating\_Support@sandwell.gov.uk](mailto:Floating_Support@sandwell.gov.uk)

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| **Office Use only:** | **Date Referral received:** |
| **Delete as appropriate: Accepted / Rejected for assessment**  If rejected: Date letter sent informing client of decision not to offer service: | |
| **Referral accepted, date allocated to assessor and assessors name:** | |
| **Client ID Number:** | |