

REFERRAL AGENCY DETAILS OR FRIEND OR FAMILY MEMBER

Name:

Email:

Job Title: Telephone:

Organisation:

Give priority for service? (please tick) High Medium Low

Do you consider this referral to be an emergency? Yes No

If Yes, please give reason:

If client has not given their consent for this referral, please contact the floating support access and referral advisor to discuss this matter.

Signature of Referrer Date

Who should we contact about this referral in the first instance? Please tick Referrer Client

PLEASE RETURN THE COMPLETED FORM TO: HOUSING FLOATING SUPPORT SERVICE, PATHS, 145 KING STREET, LONDON W6 9XY

EQUALITIES INFORMATION

AGE

Under 16 16-24 yrs 25-29 yrs
 30-39 yrs 40-49 yrs 50-59 yrs
 60 yrs or over

DISABILITY

Do you have a physical or mental impairment which has a substantial and long-term adverse effect on your ability to carry out normal day-to-day activities?

Yes No

GENDER

Female Male Transgender

ETHNIC GROUP I would describe myself as:
(Please mark one box only)

Asian or Asian British

Indian Pakistani Bangladeshi Irish

Any other Asian background (please write in)

Black or black British

Caribbean African Irish

Any other black background (please write in)

Mixed race

White and black Caribbean
 White and black African
 White and Asian

Any other mixed background (please write in)

White or white British

English Scottish Welsh Irish

Any other white background (please write in)

Chinese or other ethnic group

Chinese

Any other ethnic background (please write in)

Application for Floating Support



Important: Please provide as much information as possible about yourself/the person you are referring.

LANGUAGE

Do you need an interpreter? Yes No

Main Language:

Do you need a sign language Interpreter? Yes No

If you have problems completing the form, please contact the Housing Floating Support service on 020 8753 1437.

PERSONAL DETAILS

Title: Name:

Surname:

Address:

 Postcode

Date of birth: Preferred contact number:

CHILDREN AND OTHER PEOPLE LIVING IN AS PART OF YOUR HOUSEHOLD

Name: Relationship:

D.O.B

Name: Relationship:

D.O.B

Name: Relationship:

D.O.B

Are you or any of the above, pregnant? Yes No

Name: Due date:

PERSONAL DETAILS

Are you at risk of losing your current home? Please give details and dates you think you have to leave.

Are you at risk of losing your independence (for example, if you may have to go into a care home or hospital)? Please give date and details

What type of accommodation do you live in?

<input type="checkbox"/> Housing Association Tenancy	<input type="checkbox"/> Hospital
<input type="checkbox"/> Private Rented	<input type="checkbox"/> Street Homeless
<input type="checkbox"/> Owner Occupied	<input type="checkbox"/> Hostel
<input type="checkbox"/> Council Tenancy	<input type="checkbox"/> Temporary accommodation
<input type="checkbox"/> Friends/ Family	<input type="checkbox"/> Prison Detention
<input type="checkbox"/> Sheltered housing – Council	<input type="checkbox"/> Bed and Breakfast
<input type="checkbox"/> Sheltered housing – Housing Association	<input type="checkbox"/> Other (please state) <input type="text"/>

What help do you need to keep or stay in your home? (Please tick)

Do you need support to leave supported accommodation to live independently?	<input type="checkbox"/>
Do you need support with managing your medication and health?	<input type="checkbox"/>
Do you need support with managing your money for bills, eating or paying rent?	<input type="checkbox"/>
Do you need help with learning skills to cook, clean or shop?	<input type="checkbox"/>
Do you need help with writing letters and filling in forms?	<input type="checkbox"/>
Do you need help finding work or getting education or training?	<input type="checkbox"/>
Do you need help because you are at risk of re-offending?	<input type="checkbox"/>
Do you need help because you feel unsafe in your home?	<input type="checkbox"/>
Are you having problems staying in contact with friends and family?	<input type="checkbox"/>

Is there any thing more that you will need help with? Please write here.

We have services who work with a range of people with different needs. Please tick all of the ones that describe you:

<input type="checkbox"/> Young person and care leaver	<input type="checkbox"/> Staying with friends/ family/ NFA
<input type="checkbox"/> Victim of domestic violence	<input type="checkbox"/> Living with physical/ sensory disability
<input type="checkbox"/> Living with long-term chronic ill health	<input type="checkbox"/> Living with mental health issues
<input type="checkbox"/> Living with learning disability	<input type="checkbox"/> Drug and alcohol users
<input type="checkbox"/> Older person, elder and ageing	<input type="checkbox"/> Offender
<input type="checkbox"/> Refugee	<input type="checkbox"/> Rough sleeper or history of homelessness

RISK ASSESSMENT

So that we can make an assessment of your needs and circumstances and support you and others safely, please can you indicate if any of the risk areas below apply to you.

Risk Area	Yes	No	Risk Area	Yes	No
Abuse/Harassment from others	<input type="checkbox"/>	<input type="checkbox"/>	Risk to staff working alone	<input type="checkbox"/>	<input type="checkbox"/>
Prescription medication	<input type="checkbox"/>	<input type="checkbox"/>	History of starting fires	<input type="checkbox"/>	<input type="checkbox"/>
Accidental harm	<input type="checkbox"/>	<input type="checkbox"/>	Self-care/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>
Property damage	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalisation	<input type="checkbox"/>	<input type="checkbox"/>
Risk of being exploited	<input type="checkbox"/>	<input type="checkbox"/>	Self-harm	<input type="checkbox"/>	<input type="checkbox"/>
Exploitation of others	<input type="checkbox"/>	<input type="checkbox"/>	Fragility/Falls	<input type="checkbox"/>	<input type="checkbox"/>
Risk of financial exploitation	<input type="checkbox"/>	<input type="checkbox"/>	Sexual offending	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	Independent living skills	<input type="checkbox"/>	<input type="checkbox"/>
Substance misuse	<input type="checkbox"/>	<input type="checkbox"/>	Known risk to children	<input type="checkbox"/>	<input type="checkbox"/>

POTENTIAL RISK FACTORS AND SAFETY ISSUES

(Please include any relevant information)

To help us to support you we may need information about you held by other services such as those aware of your circumstances. We may also need to share information about you with other services. If you qualify for floating support, for example, we will share your information with the appropriate floating support service provider for them to decide if they can help and to have an understanding of your needs before meeting with you.

We will only share information where there is a need to know. We will always share information about you where you pose a serious risk to yourself or others. The intention is to ensure your safety and the safety of others.

Tick this box if you consent to us getting and using your information in this way.

It may be harder for us to provide floating support to you if you do not give consent.

SIGNATURE DATE