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|  | SP Bi Logo | Please send this form to:**E-mail:** **floating.support@newport.gov.uk****(01633 656656)** |

## Housing-Related Floating Support Referral Form (FS1)

**Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of referrer:** |  | **Date of Referral:** |  |
| **Position:** |  | **Agency:** |  |
| **Contact number:** |  | **E-mail:** |  |

**Which Service?**

*Please note that Supporting People Team may direct this referral to the most appropriate service and not necessarily as you indicate below.*

|  |  |  |
| --- | --- | --- |
| 1 | **generic service** (service provided by Taff’s The Lighthouse Project or Reach) | 🞎 |
| 2 | **for people experiencing issues with alcohol** (service provided by Kaleidoscope Project) | 🞎 |
| 3 | **for people experiencing issues with memory loss and/or dementia** (service provided by Reach) | 🞎 |
| 4 | **for people experiencing issues with domestic abuse** (service provided by Llamau) | 🞎 |
| 5 | **for people with an autistic spectrum condition** (service provided by Reach) | 🞎 |

**Applicant details**

|  |  |
| --- | --- |
| Name: |  |
| DOB: |  | SWIFT Number (if applicable): |  |
| Address: |  |
| Email Address: |  |
| Contact telephone number: |  |
| Preferred method of contact: |  |
| Indicate need/issues of the applicant: | Domestic Abuse 🞎 | Chronic Illness (inc HIV & AIDS) 🞎 |
| Learning Disability 🞎 | Young Care Leavers 🞎 |
| Mental Health 🞎 | Young People (16 to 24 years) 🞎 |
| Alcohol 🞎 | Single Parent Families 🞎 |
| Substance Misuse 🞎 | Families 🞎 |
| Criminal Offending History 🞎 | Single People (25 to 54 years) 🞎 |
| Refugee Status 🞎 | People aged 55+ 🞎 |
| Physical/Sensory Disabilities 🞎 | Memory Loss/Dementia 🞎 |
| Developmental Disorder 🞎 | Generic 🞎 |
| Does the applicant have any communication issues (eg translation service or BSL interpreter required)? |  |
| Brief overview of reasons for referral *Please remember that the main aims of these services are to support people to maintain/manage accommodation and independence.***Note: this referral will not be processed unless this section is complete.** |  |
| Are there any known risks to the applicant? **Note: this referral will not be processed unless this section is complete.** |  |
| Are there any known/potential risks to staff when visiting the applicant? *Please indicate if joint visit or an appointment at the Information Station should be undertaken)*? **Note: this referral will not be processed unless this section is complete.** |  |
| Has the applicant consented to you sending this referral, along with the information contained, to the Council’s Supporting People Team? Yes 🞎 No 🞎 |
| Have you advised and sought agreement from the applicant that information contained within this document will be forwarded to contracted support providers and may be shared with other agencies? Yes 🞎 No 🞎 |

Where possible this form should be signed by the applicant. If the applicant has not signed this form the referrer must state that verbal consent has been given for a referral to be made.

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant’s Signature: |  | Date: |  |
| Or applicant’s verbal consent to referral: Yes 🞎 No 🞎 |
| Referrer’s Signature: |  | Date: |  |
|  |  |  |  |

Please send completed form to the Supporting People Team **(****floating.support@newport.gov.uk****)**. On receipt the applicant will be contacted in order to obtain additional information / to undertake a full assessment of need.

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***To be completed by the Supporting People Team:***

Risks checked on Social Services Database: Yes 🞎 No 🞏 N/A 🞏

Specific/additional risks identified by the SP Team: Yes 🞏 No 🞎

**Details:**

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|  |

Other SP services received (if known): Yes 🞏 No 🞎

**Details:**

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| --- |
|  |

Referrer updated: Yes 🞎 No 🞏

‘Live’ spreadsheet updated: Yes 🞎 No 🞏

Other Relevant Information:

|  |
| --- |
|  |

Case note added: Yes 🞎 No 🞏

Referral e-mailed to Support Provider (if appropriate): Yes 🞏 No 🞏 N/A 🞎

Or

Appointment made for SP assessment: Yes 🞎 No 🞏 N/A 🞏