Referral Form

## About Us:

Our missions:

Kent Alpha Project CIC is a supported housing project for people seeking to establish abstinence-based lives after drug addiction (including alcohol). We provide a safe and supportive environment for a community to share working practices of the Twelve Steps together.

Our aim is to help people recover from the ravages of addiction, regain their sense of balance and wellbeing, and establish strong foundations for fulfilling and enjoyable lives, with healthy mutually beneficial relationships, and lifestyles that are sustainable in the long term.

Referral process:

This application form is the first step in a multi-step process outlined overleaf. Kent Alpha Project CIC has tried as far as possible to simplify its various forms but it is essential that a full assessment be carried out on the suitability of each candidate.

Applications will only be accepted through referral agencies. This ensures applicants have appropriate advice at all times.

## Application Form for Supported Housing

### To be completed by Client with the Referrer

We provide services for people who need support. We will use this application to help us decide if we can meet your needs. If you meet our criteria, we will invite you to an interview to discuss your needs. Information given will be treated as strictly confidential. If you need help to complete the form then please contact your referral agency.

## Personal Information

|  |
| --- |
| Applicants Full Name: |

|  |
| --- |
| Address: |

|  |  |
| --- | --- |
| Post Code: | Telephone No: |

|  |  |
| --- | --- |
| Date of Birth: | Age: |

|  |
| --- |
| National Insurance Number: |

|  |
| --- |
| Applicants Home Local Authority: |

|  |
| --- |
| Which section of the armed forces did you serve in: (IE Army, Navy, RAF etc)  |

|  |
| --- |
| Have you previously applied or resided in any supported Housing Projects? Yes No |

|  |
| --- |
| If yes, Which House(s) did you reside in? |

|  |
| --- |
| What dates did you arrive / leave? |

|  |
| --- |
| How long have you been homeless? |

## Current Situation

What types of care/support needs do you have?

|  |  |  |
| --- | --- | --- |
| Care/Support Needs | Yes/No | Description (Bullet points will suffice as needs assessment section will allow you to expand upon many of the areas below) |
| I have a mental health problem, or I have been treated for a mental health problem |  |  |
| I have a learning disability |  |  |
| I have a physical or sensory disability |  |  |
| I am single, homeless and need support |  |  |
| I am currently experiencing substance misuse problems (including alcohol)  |  |  |
| I have an addiction problem (IE gambling, sex, food)  |  |  |
| I am an offender or at risk or offending |  |  |
| I am on probation |  |  |

|  |
| --- |
| None of the above describes my particular support needs. I need care/support because: |

## Income

What is your source of income? How much do you currently receive?

|  |  |
| --- | --- |
| Long term sick or disabled |  |
| Government training program |  |
| Government New Deal Programme |  |
| JSA |  |
| Pension |  |
| Employed  |  |
| Student |  |
| No income |  |
| Other |  |

|  |
| --- |
| Do you receive any other income?  |

|  |
| --- |
| Do you have any savings?  |





Are you related to any member of Kent Alpha Project CIC’s staff or any committee member (paid or unpaid)?

 Yes No

## Additional Information

|  |
| --- |
| Please use this space to give us any other information which you think may be useful to us to assess your application. (Please continue on a separate sheet if necessary). |

Please give details of someone we can contact for further information about your application (CPN, Social Worker, Probation Officer, MOD worker or other professional who is familiar with your support needs).

|  |
| --- |
| Name: |

|  |
| --- |
| Organisation:  |

|  |
| --- |
| Telephone Number: |

|  |
| --- |
| Address: |

=============================================================

|  |
| --- |
| Name: |

|  |
| --- |
| Organisation: |

|  |
| --- |
| Telephone Number: |

|  |
| --- |
| Address: |

## Who recommended you to Kent Alpha Project CIC?

|  |  |
| --- | --- |
| Local Housing Authority |  |
| Youth Service |  |
| Police |  |
| Housing Department |  |
| Prison |  |
| Social Services |  |
| Probation Services |  |
| Voluntary Agency |  |
| Health Service/GP |  |
| Community Mental Health Team |  |
| Housing Association/RSL |  |
| Other (please specify) |  |

## Consent Form and Statement

As far as I know, the answers I have written on this form are true. I understand that Kent Alpha Project CICs reserves the right to terminate my licence to occupy any accommodation and withdraw support which has been obtained by deliberately providing false information or withholding essential information.

I hereby give permission for relevant information to be given to this organisation, in respect of my application.

Applicant’s signature ……………………………………………Date …………………

Referrer’s signature………………………………………………Date …..…………...

Job Title …………………………………………………………………………………

Needs Assessment Form
Some Questions Which You May Have

### What is it?

The Needs Assessment Form is a way of helping us to understand better what your needs are and to make sure that you get the best possible support.

### What is it for?

The form can be used in two ways.

Firstly, we will use it to collect information about all the people we house, so that we can provide the best possible service in each of our projects.

Secondly, you may wish to use a copy as a personal record of what you felt your needs were when you filled it in. This might help you to decide what, if any, changes you may want to make to your life and what help you need from us or elsewhere to make this happen.

### Who will see the form?

When the form has been completed, we will use it at your interview (along with other information you have given us) to work out whether we can offer you supported accommodation.

If you do move into our accommodation and begin to receive support, you will get a copy of the form back, and it’s then yours to do what you want with.

All information which, we keep on our applicants and tenants is held securely and only those people who need to know about your application will be allowed to look at it.

### Who fills in the form?

Your referring agency, they will have received a copy of the Application Form they will contact you to arrange a time for you to complete the form together.

The Needs Assessment Form helps us to work out how much (or little) support or help you need in different parts of your life.

### What happens next?

We will use the information in the Needs Assessment form to make sure that we can offer you sufficient support.

If you’d like to know more about the Needs Assessment Form, please ask us. If we don’t have an immediate answer, we will get back to you as soon as we can.

Needs Assessment Form

We need the information contained in this form to check whether the level and type of support which we can provide will meet your needs. Read through the whole form and complete all sections, which apply to you. There are information guidelines and questions on the opposite page to the sections, please give as much information as possible. All information given will only be shared with those people who need to know about it.

### Principal Referring Agency

|  |  |
| --- | --- |
| Name |  |
| Job Title |  |
| Organisation |  |
| Telephone number |  |
| Signature |  |
| Date |  |
| Referring agency onlyWas this form completed with your client? Yes/NoIf able please attach copies of most recent professional reports, e.g. psychiatric report/probation report/current care plan etc. |

## Section 1 - Mental Health

|  |
| --- |
| 1. Do you have any history of Mental Health Issues e.g. Schizophrenia, Bi-polar illness, Manic depression, anxiety, depression, Eating disorders or Obsessive Compulsive Disorder.2. Please give details of:* When diagnosed:
* Where you were treated:
* When you were admitted to hospital:
* How was your condition treated:
* Are you still receiving treatment:

Please give the name of the doctor who is treating you.3. Have you ever attempted to deliberately harm yourself or tried to commit suicide? Yes or No  If Yes please give further details: |

### Support

|  |
| --- |
| 1. Does your condition affect your mood and outlook on life?2. How well do you cope in social situations? |

## Section 2 - Learning Disabilities

|  |
| --- |
| 1. Do you have difficulty with:* Reading
* Writing
* Filling in forms
* Managing money (budgeting)
* Maths

2. If yes, what aspects do you find most difficult?3. Do you know why?4. How easy do you find it to socialise with other people? Do you feel a lack of confidence in social situations?5. Why do you feel this? |

### Support

|  |
| --- |
| 1. What support would help you cope or overcome some of these issues? |

Section 3 - Substance Misuse

|  |
| --- |
| Please include the following information:1. How long have you been abusing substances?2. If yes, which of the following substances do you misuse?* Alcohol
* Prescribed drugs
* Illicit drugs
* Solvents
* Others

Which types, How much, How often?3. Do you see yourself as being addicted?4. Have you attempted to resolve these problems before? If so, when?5. Did you have any support from family, friends or agencies?6. Why do you think you did not achieve your goal on that occasion?7. Are you prepared to seek support in addressing this problem? |

### Support

|  |
| --- |
| 1. What are you hoping to achieve this time?2. What would you like Kent Alpha Project CIC to do to help you reach your goals? |

## Section 4 - Physical Health

|  |
| --- |
| 1. Do you have any physical health problems?2. How long have you had this condition?3. Do you know what caused it?4. Have you ever been admitted to hospital? If yes, what was the reason?5. Are you receiving medical treatment? If not, would you like to explore if appropriate?6. How does the condition affect you? Please state whether you have problems with:* Sight
* Hearing
* Speech
* Pain
* Fatigue
* Balance or are liable to fall
* Other

7. What is your current treatment?  |

## Section 5 - Medication

|  |
| --- |
| 1. Please give details of ALL medication you are prescribed? To include:
* Name of drugs
* Dose
* Frequency

2. Are there any special instructions relating to the use of this medication e.g? * Driving or machinery operating exclusions
* Food or drink that cannot be consumed at the same time as the medication

3. Is your medication being regularly reviewed by a GP/Hospital? |

### Support

|  |
| --- |
| 1. Please tell us about any support you need.2. Are you able to manage the medication by yourself?3. Do you need reminding to:* Take your dose
* Apply for repeat prescriptions and go and collect them
 |

## Section 6 - Independent Living Skills

|  |
| --- |
| Do you need help with:* Reading
* Writing
* Filling in forms
* Managing money (budgeting)
* Maths
* Shopping / Planning menu’s
* Cooking
* Emergency procedures (calling Fire, Police, Ambulance etc.)
* Personal hygiene
* Personal laundry
* House Security
 |

## Section 7 - Culture and Religion

Please tell us in which areas of your religious or cultural life you feel you need our support.

|  |
| --- |
|  |

## Section 8 - Shared Living

Have you shared accommodation before with people from a wide range of backgrounds and with a range of abilities and behaviour?

Please tell us how you coped or how you would cope and what support you may require.

|  |
| --- |
|  |

## Section 9 - Guidance Notes

### Other Support Needs

|  |
| --- |
| Please include in this section:* Further Education
* Hobbies
* Careers Advice
* Job Training
* Counselling
* Coping with Feelings

Tell us specifically what ambitions you have in these areas. |

### Please give details of any dietary needs you have that we may assist you with.

### Please give details of the support you currently receive and from whom, by completing all sections below which apply to you.

|  |  |  |
| --- | --- | --- |
| **Person who gives me support** | **How often I see them** | **Type of support I receive from them** |
| **Partner** |  |  |
| Name:Tel No: |  |  |
| **Social Worker** |  |  |
| Name:Tel No: |  |  |
| **Psychiatric Nurse** |  |  |
| Name:Tel No: |  |  |
| **Nurse** |  |  |
| Name:Tel No: |  |  |
| **Psychiatrist** |  |  |
| Name:Tel No: |  |  |
| **Probation Officer** |  |  |
| Name:Tel No: |  |  |
| **Volunteer** |  |  |
| Name:Tel No: |  |  |
| **Friend** |  |  |
| Name:Tel No: |  |  |
| **Other (Counsellor/Psychologist)** |  |  |
| Name:Tel No: |  |  |
| Name:Tel No: |  |  |

RISK ASSESSMENT

Client Name:

Completed By

**1:** Type of risk(Tick as many as apply)

|  |  |
| --- | --- |
| Risk to self  |  |
| Risk to Others |  |
| Please tick all boxes applicable |  |
| Schedule 1/Dangerous Offender |  |
| Verbal abuse |  |
| Aggressive or intimidating behavior |  |
| Physical aggression/violence |  |
| Non-Cooperation with staff |  |
| Issues around mental illness |  |
| Issues around drug or alcohol use |  |
| Issues around street activity |  |
| Issues around criminal or anti-social behavior |  |
| Discriminatory verbal abuse |  |
| Damage to property |  |
| History of rape or sexual assault |  |
| Accidental fire setting |  |
| Arson |  |
| Lone working considered unsafe  |  |
| Female lone working considered unsafe |  |
| Hoarding |  |
| Please use the space below to specify any risk factors linked to the behaviours identified above:  |  |
|  |  |

## 2: Detail of risk (Include details of last know incident where relevant & frequency)

|  |
| --- |
|  |

3: Who is at risk? (Tick as many as apply and provide details where appropriate in the space provided)

|  |  |
| --- | --- |
| Client |  |
| Staff |  |
| Neighbours |  |
| Contractors |  |
| Specific individual(s) (specify) |  |
|  |
| High  |  |
| Medium  |  |
| Low  |  |
| No Known Risk |  |

## 4: Assessment of Risk

## 5: Risk Assessment Action Plan

|  |
| --- |
| Triggers / behavior to be aware of |

|  |
| --- |
|  What actions have you taken (or suggest) to manage risk with the applicant.  |

6: Is the applicant aware of this risk assessment? Yes/No

Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PLEASE PRINT AND SIGN NAME