  

**SUPPORTED HOUSING APPLICATION FORM**

Name of Service...................................................................

Referred by...................................................................

Position...................................................................

Address...................................................................

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Telephone Number...................................................

Please forward the completed referral form, together with a care plan and full social report which should indicate the reasons for the referral, background information and any other details which you feel may be of relevance/support to the application to:-

**Zoe Alexander**

**SERVICE MANAGER, Taylor Cheshire House**

zoe.alexander@threshold-services.co.uk

**FOR OFFICE USE ONLY**

**Referral form completed Yes/No Date received/details**

**Social report provided Yes/No Date received/details**

**Care plan provided Yes/No Date received/details**

**Date of Referral Meeting .......................................................**

**PERSONAL DETAILS**

Name: ...............................................................................

Married/Single/Divorced/Separated/Widowed ............................................................................................

Date of Birth:.......................................................................

Height:...................................................................... Weight:.........................................................................

Does applicant wear dentures Yes/No

National Insurance No:...................................Medical Number:...................................................

Present Address:..................................................................................................................... ..............................................................................................................................................

Post Code: ...............................................Telephone No: .......................................................

Home Address (if different from above)....................................................................................

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Post Code .................................................Telephone No:......................................................

Next of Kin................................................Relationship to Applicant.......................................

Address..................................................Telephone Number....................................................

Family Structure: .....................................................................................................................................................

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Religion: ............................................Does Applicant practise his/her religion. Yes/No............

Does applicant attend a particular place of worship (Please give details)................................... .....................................................................................................................................................

Priest/Minister.............................................................................................................................

Current GP:.................................................................................................................................

Address:....................................................................Telephone No:..........................................

Current Dentist:..........................................................................................................................

Address:...................................................................Telephone No:..........................................

Current Chiropodist:..................................................................................................................

Address:.............................................. .....................Telephone No:........................................

Named Social Worker:................................................................................................

Referral Agent (if different).....................................................................................................

Other agencies/professionals involved:.....................................................................................

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**Housing Related Support required**

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| --- | --- | --- |
| **Type of Support** | **Yes** | **No** |
| Tenancy set ups/safety and security in the home/finding alternative accommodation |  |  |
| Maintaining the home |  |  |
| Life Skills |  |  |
| Budgeting/Benefits and finance |  |  |
| Family Contact/Current relationships/encouraging good neighbour relations |  |  |
| Advice on shopping and errands |  |  |
| General physical health |  |  |
| Mental health issues |  |  |
| Alcohol and drug use/misuse |  |  |
| Social and leisure activities |  |  |
| Social inclusion and empowerment/accessing other services |  |  |

**Care/Self help skills: Please tick as appropriate.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| SKILL AREA | INDEPENDENTLY | WITH SUPERVISION | WITH HELP | NOT AT ALL |
| Wash |  |  |  |  |
| Dress |  |  |  |  |
| Shave (male) |  |  |  |  |
| Manage Menstruation |  |  |  |  |
| Eat |  |  |  |  |
| Drink |  |  |  |  |
| Road Safety |  |  |  |  |
| Public Transport |  |  |  |  |
| Literacy/numeracy |  |  |  |  |
| Mobility |  |  |  |  |
| Use toilet |  |  |  |  |
| Prepare a light meal |  |  |  |  |
| Make tea/coffee |  |  |  |  |
| Personal laundry |  |  |  |  |

Please detail any risks Re: any of the above areas.............................................................................................................................

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Does applicant know the value of money.....................................................................

Can he/she manage his/her own finances?.................................................................................

Does applicant smoke? Yes/No

Risks identified

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Does applicant drink alcohol? Yes/No

Risks identified

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Is the resident sexually aware/active? - Please give details, together with any risks identified

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**GENERAL INFORMATION**

Day Care arrangements...............................................................................................................

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Transport arrangements ......................................................................................................................................................

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Applicant's attitude towards proposed placement

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Is Family contact maintained? Yes/No With Whom..................................................................

Parent's/Guardian's/Carer's attitudes towards proposed placement............................................

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Please give details of any special arrangements re family contact/visits

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Diet: please give details of likes/dislikes or any special dietary requirements

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Details of normal sleep pattern.....................................................................................................

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Is there any history of violence/aggressive behaviour? Yes/No Please give details...................

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Does the applicant have any criminal record or has he/she committed any offences in the past?

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Needs Identified...........................................................................................................................

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Risks Identified............................................................................................................................

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Any other details which you feel may be of relevance to the referral......................................... ......................................................................................................................................................

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**PREVIOUS PLACEMENTS**

Please give details (including dates) of all schools/day care/work placements attended

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Please give details (including dates) of previous residential placements

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**FINANCIAL DETAILS**

Benefits received .....................................................................................................................................................

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Care management arrangements..................................................................................................

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Appointee for financial affairs.....................................................................................................

Address........................................................................................................................................

Post Code............................................ Telephone No:...........................................................….

Has applicant made a will? Yes/No If yes, who holds the details?............................................

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Has applicant/family made any funeral arrangements? Yes/No If yes, who holds the details?

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**COMPLETED BY**

Name:...........................................................................................................................................

Position.........................................................................................................................................

Address.........................................................................................................................................

Signature ....................................................................... Date......................................................

**MEDICAL ASSESSMENT**

To be completed by the applicants GP/Consultant/other medical professional

Name of Service User............................................Date of Birth ................................................

Mental Health Issues....................................................................................................................

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Physical Disability........................................................................................................................

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Epilepsy .......................................................................................................................................

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Brief description of seizures......................................................................................................... ......................................................................................................................................................

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Sensory Disability........................................................................................................................

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Challenging Behaviours............................................................................................................... ......................................................................................................................................................

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Previous medical history (please give details of any serious illnesses)......................................

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Other relevant medical details (including recent hospital admissions).......................................

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Current medication....................................................................................................................... ............................................................................................................................................................................................................................................................................................................

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Allergies.............................................................................................................................................................................................................................................................................................

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Any other medical information which you feel may be relevant to this referral

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**Completed by**

Name....................................................................................................................................................................................................................................................................................... Position..............................................................................................................................................................................................................................................................................................

Address....................................................................................................................................................................................................................................................................................

Signature.................................................................. Date ....................................................