|  |  |  |  |  |  |  |  |  |
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|  | | | | | | | | |
| Submission of this referral confirms that you have gained consent from the person to do so. This also includes their agreement to the exchange of information between agencies who are providing support and they have given consent to have basic personal information stored on Sheffield City Councils Housing Support Pathway. | | | | | | | | |
| **Eligibility Criteria** | | | | | | | | |
| **Our service provides support to people who**:   * Are aged 55+ * Have an age-related health condition or deterioration in health. * Require a short period of support to remain independent at home or regain independent living and confidence following discharge from hospital or residential care. * Live in Sheffield * Have consented to this referral and are willing to engage in support from a keyworker   **Wherever possible we will offer priority assistance if one or more of the following applies:**  Discharge from hospital is delayed or is dependent on support   * Risk of eviction or homeless within 28 days * Moving within 28 days or property signed for * No income or benefits stopped   No heating or food | | | | | | | | |
| **Referrer Details** | | | | | | | | |
| Is this a self-referral: Choose an item. | | | | Has consent been given: Choose an item. | | | | |
| **Professional** | | | | | | | | |
| Name: | | Job Title: | | | | Email: | | |
| Tel: | | | | | Referral agency: | | | |
| **Family / Friends** | | | | | | | | |
| Name: | | | | | Relationship: | | | |
| Tel | | | | | Email: | | | |
| **Personal Information** | | | | | | | | |
| **Name:** |  | | | | **Title** | | Choose an item. | |
| **Tel No:** |  | | | | **Email:** | |  | |
| **DOB:** | Click or tap to enter a date. | | | | **Gender Identity:** | | Choose an item. | |
| **Nationality:** | Choose an item. | | | | **Ethnicity:** | | Choose an item. | |
| **Language Spoken:** | Choose an item. | | | | **Interpreter Needed:** | | Choose an item. | |
| **Sexual Orientation**: | Choose an item. | | | | **Ex Service Personnel:** | | Choose an item. | |
| **Religion** | Choose an item. | | | | **Literacy:** | | Choose an item. | |
| **Smoker:** | Choose an item. | | | | **Pets:**  **Type of Pet:** | | Choose an item.Choose an item. | |
| **Health Information** | | | | | | | | |
| **Do you have an age-related health condition or deterioration in your health? Please select:**  Age Related Health Condition  Deterioration in health  **Please provide further details:**  **Do you have a disability: Yes  No  Don’t know**  **What is your primary disability?** Choose an item.  **Disability other:** | | | | | | | | |
| **Address Information** | | | | | | | | |
| **Home Address:**  **Post Code:**  **Tenure:** Choose an item.  \*Housing Associations: Choose an item.  \*Other:  If you are a referrer from **SCC Neighbourhoods Teams or a Housing Association,** please provide reasons below why additional support from this service is being requested:  **Any known access issues** (use back door, wait after knocking, bell doesn’t work etc.)  **Best times to contact:**  **Key Safe:** Choose an item. (If yes pls contact office) | | | | | **Temp address (e.g., hospital- please state ward)**  **Is discharge delayed:** Choose an item.  **Date admitted:** Click or tap to enter a date.  **Date of discharge:** Click or tap to enter a date. | | | |
| **Support needs** | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | **Please tick the ALL the areas you are requesting support with:** | | | | |  | Support to maximise Income / debt help |  | Support to access benefits / grants | |  | Support to access aids and adaptations |  | Support with being safe in your home | |  | Support with hospital discharge |  | Support to access health services | |  | Support to reduce social isolation |  | Support to access community activities | |  | Support to access to education, training, or employment |  | Support to access drug and alcohol support services | |  | Support with cultural/religious needs |  | Accessing other specialist support (please detail below) | |  | Support with rehousing (**see below**) |  |  |   **Further details required for rehousing:**  Are you registered for housing? Choose an item.  Is a medical priority required? Choose an item.  Has a priority application already been made? Choose an item. | | | | | | | | |
| **Please provide detailed reasons for requesting support:** | | | | | | | | |
| **Other Support (please provide details:** | | | | | | | | |
| **Friends / Family** | | | | | **Support Services / Professionals** | | | |
| Name:  Tel:  Email:  Relationship:  Support: | | | | | Name:  Tel:  Email:  Service:  Support: | | | |
| Name:  Tel:  Email:  Relationship:  Support: | | | | | Name:  Tel  Email:  Service:  Support: | | | |
| Name:  Tel:  Email:  Relationship:  Support: | | | | | Name:  Tel  Email:  Service:  Support: | | | |
| **Risks and Safeguarding (please select any risks below)** | | | | | | | | |
| Can they be interviewed Alone | | | Yes: No: | | Active Substance User | | | Yes: No: |
| Any self-harm | | | Yes: No: | | History of Arson | | | Yes: No: |
| Recent Accommodation Ban | | | Yes: No: | | History of Violence to others | | | Yes: No: |
| Serious offending history | | | Yes: No: | | History of violence to staff | | | Yes: No: |
| Subject to MAPPA consideration | | | Yes: No: | | Anger Management | | | Yes: No: |
| Potential Danger to Women | | | Yes: No: | | MARAC | | | Yes: No: |
| In safeguarding | | | Yes: No: | | Other | | | Yes: No: |
| **If any risks or safeguarding are ticked above, please provide more detail below:** | | | | | | | | |
| **Self-Referrals** | | | | | **Professionals** | | | |
| Is it safe for us to visit you at home? Choose an item.  If not, please state why: | | | | | If you have visited the client at home: Choose an item.  Is it safe to visit as a lone worker: Choose an item. | | | |
| **Please include any additional assessments that may assist us with triaging your referral** | | | | | | | | |
| **OFFICE USE ONLY** | | | | | | | | |
| **Date of Referral:** | | | | | **Accepting Staff Member:** | | | |
| **HSP Number: Date placed:** | | | | | **Conflict check: Y/N Date on Inform:** | | | |

Please return by email to [LivewellatHome@syha.co.uk](mailto:LivewellatHome@syha.co.uk)

If you need to speak to us regarding your referral, please call on 0114 290 8359