

Application for housing 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: (Mr, Mrs, Miss, Ms) First name:

Family name:

Address:

 Postcode

Date of birth: Preferred contact number:

CHILDREN AND OTHER PEOPLE LIVING WITH YOU 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 if 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 |
| <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 style="width: 200px;" type="text"/> |

Are you aged 60 or over and moving home? Yes No

Do you need support (Please tick)

- | | |
|---|--------------------------|
| To leave supported accommodation to live independently? | <input type="checkbox"/> |
| Accessing health services to stay well? | <input type="checkbox"/> |
| With managing your money to pay your bills, or rent? | <input type="checkbox"/> |
| Learning skills to cook, clean or shop? | <input type="checkbox"/> |
| Writing letters and filling in forms? | <input type="checkbox"/> |
| Finding work, education or training? | <input type="checkbox"/> |
| Because you feel unsafe in your home? | <input type="checkbox"/> |
| To stay in contact with friends and family? | <input type="checkbox"/> |

Is there anything else 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 or care leaver | <input type="checkbox"/> Experiencing 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 a learning disability |
| <input type="checkbox"/> Drug or alcohol use | <input type="checkbox"/> Older person |
| <input type="checkbox"/> Offender/Ex-offender | <input type="checkbox"/> Refugee |
| <input type="checkbox"/> Rough sleeper or history of homelessness | |

So that we can carry out an assessment of your needs and support you and others safely, please indicate if any of these apply to you.

Risk Area	Yes	No	Not known	Risk Area	Yes	No	Not known
Abuse/harassment from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Risk to staff working alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	History of starting fires	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accidental harm/Self neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-care/hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Property damage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of being exploited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-harm or suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exploitation of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fragility/falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of financial exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gambling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Known risk to children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If this form is being completed by a professional, please comment on any potential risk factors and safety issues posed by your client. (Please include any relevant information)

To help us to support you we may need to receive and share information about you held by other services. If you qualify for floating support, 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.

Tick this box if you consent to us 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

REFERRAL AGENCY DETAILS OR FRIEND OR FAMILY MEMBER

Name:

Relationship to applicant:

Email:

Job Title: Telephone:

Organisation:

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

If Yes, please give reason:

If applicant has not given their consent for this referral, please contact the housing floating support service to discuss this matter on 020 8753 1437.

Signature of Referrer Date

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

**PLEASE RETURN THE COMPLETED FORM TO: HOUSING FLOATING SUPPORT SERVICE, PATHS, 145 KING STREET, LONDON W6 9XY.
EMAIL: housing.support@lbhf.gov.uk or fax 020 8753 5094**

EQUALITIES INFORMATION

This information does not form part of our assessment. It is used for planning services and ensuring we are accessible to all.

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
Any other Asian background (please write in)

Black or Black British

- Caribbean African

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

- British Irish Other

Any other white background (please write in)

Chinese or other ethnic group

- Chinese

Any other ethnic background (please write in)