Application for housing floating support

Important: Please provide as much information as possible about yourself/the person you are referring. Please mark boxes with an **'X'.**
Please fully complete the risk assessment and ensure you get permission from the client before referring to floating support.

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: ☐

Current Address: ☐

Address you are moving to and expected tenancy start date (if applicable):

☐

Date of Birth: ☐ / ☐ / ☐ Preferred contact number: ☐

Email address: ☐

CHILDREN AND OTHER PEOPLE LIVING WITH YOU AS PART OF YOUR HOUSEHOLD

Name: ☐ Relationship: ☐

Date of Birth: ☐ / ☐ / ☐

Name: ☐ Relationship: ☐

Date of Birth: ☐ / ☐ / ☐

Name: ☐ Relationship: ☐

Date of Birth: ☐ / ☐ / ☐

Are you or any of the above pregnant? ☐ Yes No ☐

PERSONAL CIRCUMSTANCES

Important: Please answer Questions 1-3 with as much relevant information as possible, clearly stating any issues you need support with using the text box provided.

1. Are you at risk of losing your current home? Yes ☐ No ☐
If yes, please give specific details of your situation and dates if you think you have to leave.

2. What is the main reason for your referral? (please give details and provide a summary of current issues you are facing and ongoing support needs)

3. Are you at risk of losing your independence (for example, if you may have to go into a care home or hospital)? Yes ☐ No ☐
If yes, please give details.

4. Are you at risk of or experiencing domestic violence?
Yes ☐ (please answer questions 4.1 - 4.2) No ☐ if no, please move on to question 5

4.1 Applicant details:

Name of person at risk:		Alternative contact number:	
Address: Is this address safe to write to? Is this address safe to visit?	 Yes ☐ No ☐ Yes ☐ No ☐	Email:	
Alternative safe contact address (if applicable):		Name at contact address:	
Telephone number:	Is it safe to leave a message on this number? Yes ☐ No ☐		
Next of Kin:		Relationship:	
Their contact number:	Is it safe to leave a message on this number? Yes ☐ No ☐		
G.P. Name:		G.P. Address:	
G.P. Fax:		G.P. Tel:	

4.2 DV History

Date of last incident:		Did you seek medical assistance?	Yes ☐ No ☐
Was the incident reported to the police? Crime Reference No:	Yes ☐ No ☐	Dates of previous incidents:	
Please write a summary below of the last incident:			

5. What type of accommodation do you live in?

☐ Housing association tenancy	☐ Hospital
☐ Private rented	☐ Street/Homeless
☐ Owner Occupied	☐ Hostel
☐ Council Tenancy	☐ Temporary accommodation
☐ Friends/Family	☐ Prison
☐ Sheltered housing	☐ Bed & Breakfast
☐ Other (please state)	☐ Supported Accommodation (what type?)

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

6. Is this referral part of the move-on from supported accommodation Early Referral protocol? Yes ☐ No ☐

7. Do you need support (Please tick all relevant support needs)

To leave supported accommodation to live independently? ☐

Accessing health services to stay well? ☐

With managing your money to pay your bills or rent? ☐

Learning skills to cook, clean or shop? ☐

Writing letters and filling in forms? ☐

Finding work, education or training? ☐

Because you feel unsafe in your home? ☐

To stay in contact with friends and family? ☐

7. If there is anything else that you need support with, please write details here:

SUPPORT NEEDS

We have services who work with a range of people with different needs.
Please tick all of the ones that describe you:

- ☐ Young person or care leaver
- ☐ Living with physical/sensory disability
- ☐ Living with mental health issues
- ☐ Drug use
- ☐ Alcohol use
- ☐ Offender/Ex-offender
- ☐ Experiencing domestic violence / abuse
- ☐ Living with long-term chronic ill health
- ☐ Living with a learning disability
- ☐ Older person
- ☐ Rough sleeper or history of homelessness
- ☐ Refugee

RISK ASSESSMENT
Important: We may not be able to proceed with your referral if the relevant risk information has not been provided.
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. Where a risk has been identified, please include details in the text box below.

Risk Area	Yes	No	Not Known	Risk Area	Yes	No	Not Known
Abuse/harassment from others	☐	☐	☐	Risk to staff working alone	☐	☐	☐
Medication compliance	☐	☐	☐	History of starting fires	☐	☐	☐
Accidental harm/Self neglect	☐	☐	☐	Self-care/hygiene	☐	☐	☐
Property damage	☐	☐	☐	Hospitalisation	☐	☐	☐
Risk of being exploited	☐	☐	☐	Self-harm or suicide	☐	☐	☐
Exploitation of others	☐	☐	☐	Fragility/falls	☐	☐	☐
Risk of financial exploitation	☐	☐	☐	Sexual offending	☐	☐	☐
Gambling	☐	☐	☐	Drug use	☐	☐	☐
Known risk to children	☐	☐	☐	Alcohol use	☐	☐	☐
Infestations / pests	☐	☐	☐	Potential / Actual Violence	☐	☐	☐

You must provide details of any identified or potential risk factors and safety issues. If this is not completed the referral will not be processed, please write details here:

Do you have a separate risk assessment available on request? Yes ◯ No ◯

CONSENT (please read)
To help us to support you we may need to receive and share information about you held by other services. 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 risk to yourself or others. If you are making this referral on behalf of someone else, please ensure you have discussed this referral with them and have received their consent to make a referral:
Please mark the relevant box with an 'X'
A. I am the client and have read the above and consent to you using my information in this way. ☐
B. I am making this referral on behalf of my client. I confirm I have their consent to make this referral and they consent to using their information in this way. ☐
Please note, we may not be able to offer floating support to you if you do not give consent

SIGNATURE _____ DATE ☐☐ / ☐☐ / ☐☐☐☐

DETAILS OF REFERRER

Name:

If this is a self-referral, where did you hear about this service?

Relationship to applicant:

Email:

Job title: Telephone:

Organisation:

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

If Yes, please give reason:

Signature of Referrer: Date: / /

Who should we contact about this referral in the first instance? Please mark with an 'X'

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

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 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 -

- Asian or Asian British

Indian Pakistani Bangladeshi

Any other Asian background (please write in)

-Black or Black British

Caribbean African

Any other background

- **Mixed Race**

White and Black Caribbean

White and Black African

White and Black Asian

Any other mixed background (please write in)

- **White**

British Irish Other

-Chinese or other ethnic group (please write in)