Application for Housing

Floating Support

**Housing Floating Support is designed to help you sustain your tenancy and prevent homelessness.**

**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 Main language:

**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:

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

National Insurance Number:  Email address:

Next of Kin contact number:

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

Name of pregnant person: Relationship to main client:

Are you currently involved with any other support services? Please provide details:

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 explain the reasons that you have to leave and when you have to leave

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

**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)Noif 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?)

**6. Is this referral part of the move-on from Supported Accommodation?** Yes  No

**7. What Housing support do you need (Please tick all relevant support needs)**

To leave supported accommodation to live independently

Support with adaptations to the home

Managed transfer due to health challenges, neighbour disputes etc

Accessing health services to stay well

With managing your money to pay your bills or rent

Finding work, education or training

Resettlement support when moving into a new home

Support with benefits such as Universal Credit or PIP

**8. 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  Experiencing domestic abuse

Living with physical/sensory disability  Living with long-term chronic ill health

Living with mental health issues  Living with a learning disability

Drug use       Older person

      Alcohol use       Rough sleeper or history of homelessness

Offender/Ex-offender  Refugee

**RISK ASSESSMENT**

**Important: Please Indicate if there is current or past risks in any of the following areas:**

**If not completed your form will be returned.**

Risk Area Yes No Risk Area Yes No

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 risk factors and safety issues. If this is not completed the referral will not be processed, please write details here:**

**NOTE: PLEASE INCLUDE A SEPARATE RISK ASSESSMENT**

**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:

Date of last contact with service user:

Email:

Job title/Organisation:  Telephone:

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**

**EMAIL:** [**housing.support@lbhf.gov.uk**](mailto: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 -Black or Black British**

Under 18 18-24 yrs  25-29 yrs  Caribbean  African       Any other background

30-39 yrs  40-49 yrs  50-59 yrs - **Mixed Race**

White and Black Caribbean

60 yrs or over       White and Black African

      White and Black Asian

Any other mixed background (please write in)

**DISABILITY**

Do you have a physical or mental impairment

which has a substantial long-term adverse effect on - **White**

your ability to carry out normal day-to-day activities?       British       Irish       Other

**-Chinese or other ethnic group** (please write in)

Yes  No

**GENDER**

Female  Male

Transgender  Other

**ETHNIC GROUP** I would describe myself as -

**- Asian or Asian British**

Indian  Pakistani  Bangladeshi

Any other Asian background (please write in)