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

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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)

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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.

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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?)

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:

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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

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 18 [ ] 18-24 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 [ ] Other

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)
[ ]