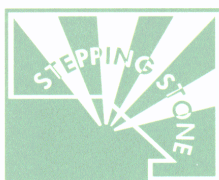


Stepping Stone Project



Referral Form

Wigan Complex Needs Floating Support Service

(Wigan CNS)

Floating Support Service
Redfearn House
Ings Avenue
Rochdale
OL12 7LH
Tell 01706 359600
Fax: 01706 345302
Email: floatingsupport@stepping-stone.org.uk

Eligibility

The service will consider applications from people at risk of becoming homeless aged 16-65 yrs who have complex or multiple needs including substance and alcohol misuse, offending behaviour, and mental health issues, and who need a medium to high level of support

The service is primarily a housing-related support service. However, support in meeting other non housing- related needs will be met through partnership working and signposting to appropriate agencies

Stepping Stone Project does not have a blanket exclusions policy. Applications may be refused where the applicant's needs do not match the aims of the service, such as where:

- Applicants do not require a housing related support service
- Risks associated with the delivery of the service cannot be managed
- Applicants have low level support needs, and therefore do not require the service.
- Applicants refuse to sign the declaration or disclaimer section of the interview form.
- Applicants have knowingly failed to declare or given false information at the interview stage.

This is not an exhaustive list and referrals may not be successful for other reasons. All applications will be considered on their own individual circumstances.

All applicants need to demonstrate a willingness to engage in the support provided, although Stepping Stone recognise that the Service Users we will be working with may be living a very chaotic lifestyle.

Where a referral is not accepted the applicant and referral agency (if applicable) will be contacted and advised in writing of the reasons for this decision. Advice and information will be offered to the applicant, on other options for alternative support.

The applicant will also be advised of the appeals procedure.

Referrals can be made by any agency or the applicant themselves. Referrals can be made by e-mail, telephone, fax, post, or by the applicant presenting in person to the drop in sessions held throughout the Borough

Section A. Applicant Details

Name		
Gender	Male	Female
Current address		
NI Number		
Date of Birth		
Telephone number		
First Chosen language		Interpreter required
Is the Applicant aware this referral is being made?	Yes	No (Please make the applicant aware)

Section B. Referring Agency details

Date	
Referring Agency	
Contact person	
Contact number and email	

Section C. Housing Related Support Need

What Housing Issues do you think the service user needs support with?
Please tick

Support required	A lot	Some	None
Help with running a tenancy/own home			
Help with registering with utilities			
Developing skills to complete forms			
Developing skills to access/apply for welfare benefits			
Accessing furniture / applying for community care grants etc.			
Dealing with rent arrears / housing benefit / council tax			
Developing budgeting and shopping skills			
Social and communication skills			
Developing cooking skills			
Advice in relation to Cleaning			
Advice in relation to Personal hygiene			
Literacy and/or numeracy			
Accessing employment, education / training			
Accessing leisure and local activities			

Other Support Needs

Is the service user responsible for any dependent children?

If yes please provide details

Do dependent children live with the service user?

Does the service user have a drug misuse problem now or in the past?

If yes please provide details including current treatment.

Does the service user have an alcohol misuse problem now or in the past?

If yes please provide details including current treatment

Does the service user need support in relation to mental health?

If yes please provide details

Has the service user ever had suicidal thoughts or self harmed?

If yes please provide details

Please state fully any previous convictions the service users may have:

Has the service user ever had any prison sentences/court orders due to convictions?

If yes please provide details

Does the service user have any ongoing support needs in relation to reducing offending behaviour?

If yes please provide details

<p>Does the service user have any physical health problems? <input type="checkbox"/></p> <p>If yes please provide details</p>
<p>Does the Service User have any history of violence or aggressive behaviour? <input type="checkbox"/></p> <p>If yes please provide details</p>
<p>Is this person suitable to receive home visits from a lone worker? <input type="checkbox"/></p>
<p>Does the service user require home visits specifically from a female or male support worker? <input type="checkbox"/></p> <p>If yes please specify</p>
<p>Is the service user currently taking any medication? <input type="checkbox"/></p> <p>If yes please provide details</p>
<p>Does the service user exhibit any learning difficulties? <input type="checkbox"/></p> <p>If yes please provide details</p>

Please give details of any agencies and workers currently supporting service user.

Name	Agency/service	Contact no

Section D. Accommodation History

Is the service user currently?

Council tenant <input type="checkbox"/>	Living with friends /relatives <input type="checkbox"/> and moving to a new home Please give date of move.....
Housing assoc <input type="checkbox"/>	Hostel / Supported accom. <input type="checkbox"/> and planning to move on Please give date of move
Private rented <input type="checkbox"/>	Sleeping rough <input type="checkbox"/>
Owner Occupier <input type="checkbox"/>	Foster Care / Children's home <input type="checkbox"/>
B&B <input type="checkbox"/>	Probation / Bail hostel <input type="checkbox"/>
Hospital <input type="checkbox"/>	Residential Care home <input type="checkbox"/>
Prison <input type="checkbox"/>	Other ... <input type="checkbox"/>

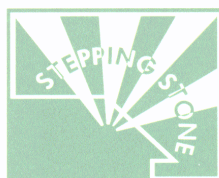
Section E. Date and Signature of person making the referral

Signature:

Print Name:

Capacity:

Date:



STEPPING-STONE PROJECT SERVICE USER RISK ASSESSMENT FORM

NAME		DATE OF BIRTH	
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ADDRESS	
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Presenting Problems (including views of service user, support staff and referrer):

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Danger / Risk to Others	Current	Previous History	Brief Description of the risk and how it will be managed (if applicable)	Are Risk Low, Medium or High
Aggression / Violence to Others				
Arrest for Violence				
Conviction for violent or sexual offence				
Preoccupation / Obsession with weapons				
Arson / Fire Setting				
Hostage Taking				
Threats to kill / harm others				
Sexual abuse / Other abuse towards others				
Stalking / Harassment				
Other				

Self Harm	Current	Previous History	Brief Description of the risk and how it will be managed (if applicable)	Are Risk Low, Medium or High
Suicidal Attempts				
Suicidal Ideation				
Suicidal Plans				
Self-harm / Injury (e.g. cutting, poisoning, burning)				
Substance Misuse				
Other				

Self Neglect	Current	Previous History	Brief Description of the risk and how it will be managed (if applicable)	Are Risk Low, Medium or High
Poor nutrition				
Poor personal hygiene				
Unable to cook / have good diet				
Unable to wash / dress self				
Poor budgeting				
Other				

Vulnerability	Current	Previous History	Brief Description of the risk and how it will be managed (if applicable)	Are Risk Low, Medium or High
Non-compliance with medication				
Disengagement from mental health services				
Recent bereavement or loss				
Sexual abuse / other abuse				

Victimisation				
Recent Discharge				
Recent Pregnancy				
Other				

Assessment completed by:

TITLE		NAME	
ADDRESS			
TELEPHONE			
FAX			
EMAIL			
RELATIONSHIP TO YOU			

Are you lacking appropriate information or unable to fully assess for other reasons? <i>If yes, please describe:</i>	Yes / No

Signature:		Date:	
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Review Date:	
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