STEPPING STONE PROJECTS

Referral
AND
Risk Assessment
Form

Low Level Support Needs
Accommodation Project

Stepping Stone Projects
Central Referral and Assessment Team
PO Box 153
Rochdale
OL16 1RF

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Personal Details

Today's Date	
Name	
Date of Birth	
Ethnic Origin	
Current Address **Current Landlord (if applicable)**	
Contact telephone number	
National Insurance number	
Do you have any dependants?	
If so, please state their names and ages.	
Which Service are you applying to? Please tick	**Parkside**

Accommodation History

Please provide details by ticking the appropriate box if any of the following problems were encountered in current or previous accommodation?

Address	Current tenancy arrears	Former tenant arrears	Recharges	Hsg Benefit Overpayment	Anti Social Behaviour	Abandonment	Other Issues

If you have ticked yes to any of the above please provide further details

_____

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Have you previously ever used any of the services offered by Stepping-Stone?

- ☐ **Yes**
- ☐ **No**

1) If YES which services have you used and who was your link worker / Floating Support Worker / Advice Worker?

Project	Dates if known	Support Worker
Parkside		
Redfearn House		
Ashburn House		
Westgate		
Spa Mill		
Spenser St		
Other Please state		

2) How did you find out about the service we offer?

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3) Do you need any help or advice with any of the following?

INITIAL SUPPORT ASSESSMENT

Outcome	Area of support	Examples	Do you feel you need support with this?
ACHIEVE ECOMOMIC WELL BEING	**MANAGING MONEY**	**Claiming Benefits / IS, JSA, etc**	
		Claiming and sustaining Housing Benefit	
		Maximising Income	
		Claiming Grants / Allowances	
		Budgeting	
		Managing debts	
		Setting Up and maintaining Payment Plans	
		Access specialist services	

		Gambling Issues	
ENJOY AND ACHIEVE	**USE OF TIME**	**Educational opportunities**	
		Training Opportunities	
		Client Involvement	
		Hobbies & Interests	
		Leisure opportunities	
		Parenting Skills	
		Cultural / Faith Needs	
	FAMILY AND RELATIONSHIPS	**Improving relationship Partner**	
		Improving Family relationships	
		Establishing Social Networks	
BE HEALTHY	**PHYSICAL HEALTH**	**Accessing primary health care / GP**	
		Reduce Crisis situations	
		Keeping healthy	
		Anger management	
		Sexual health	
	EMOTIONAL OR MENTAL HEALTH	**Managing depression / anxiety**	
		Managing mental health	
		Link in to mental health related services	
		Emotional stability	
	DRUGS, ALCOHOL, OTHER ADDICTIONS	**Link in with specialist alcohol support services**	
		Link in with specialist drug support services	
		Manage substance misuse	
	KEEPING HOUSE AND SELF CARE	**Cooking**	

		Cleaning	
		Shopping	
		Personal Safety	
		Personal Hygiene	
		Familiarise with local facilities and services	
STAY SAFE	**ABILITY TO MANAGE TENANCY**	**Managing visitors**	
		Paying rent & charges	
		Understanding Tenancy Rights & Responsibilities / Tenants & Landlords	
		Understanding Tenancy Agreement	
		Setting Up New Tenancy	
		Utilities	
		Accessing Furniture	
		Finding a more permanent home	
		Ongoing housing related support	
	OFFENDING	**Reducing Offending Behaviour**	
		Compliance with probation requirements	
		Reduce / stop anti social behaviour	
	PHYSICAL HEALTH	**Reduce Self harm**	
		Reduce harm to others	
		Minimise risk of harm from others	
MAKE A POSITIVE CONTRIBUTION	**INTERNAL JOURNEY MOTIVATION**	**Self Esteem**	
		Motivation	
		Taking Responsibility	

		Communication	
		Problem Solving	

Are there any other areas that you feel you may need some support with which was not covered in the above list?

5) Please explain what specific issues you are experiencing and how you feel our project can assist you.

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Do you have a history of? Please tick

	Current	Past
Drug Misuse		
Alcohol Abuse		
Mental Health		
Violence		
Physical Health Problems		
Learning Difficulties		
Learning Disabilities		

Please complete the appropriate contact details if you have been supported by any agencies around the following issues

	Agency Contact Name and address
Drug Misuse	
Alcohol Abuse	
Mental Health	
Violence	
Physical Health Problems	
Learning Difficulties	
Learning Disabilities	

Do you have any convictions relating to? Please tick

	Yes	No	Not Known
Arson			
Assault			
Burglary			
Criminal Damage			
Drugs			
Sexual Offences			
Theft			
Violence			

If you have ticked yes to any of the above please could you provide further details of the offence committed?

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Please select the best means of confirming the date, time and place of the needs and risk assessment meeting:

- letter
- telephone
- text
- email

Client Declaration

I understand that the information given on this form is to the best of my knowledge true and correct. I understand that if I have knowingly given false information this may jeopardise my acceptance onto the scheme.

I agree to inform Stepping Stone of any changes in my circumstances.

Signed:

Date:

STEPPING-STONE PROJECTS
CLIENT RISK ASSESSMENT FORM

NAME		DATE OF BIRTH	
ADDRESS			

Presenting Problems (including views of client, support staff and referrer):

Danger / Risk to Others	Current	Previous History	**Brief Description of the risk, trigger factors and signs**	Are Risk Low, Medium or High
Aggression / Violence to Others				
Violence towards staff				
Arson / Fire Setting				
Sexual abuse				
Other				
Self Harm	Current	Previous History	**Brief Description of the risk, trigger factors and signs**	Are Risk Low, Medium or High
Any Suicidal Attempts, thoughts or plans				
Self-harm / Injury (e.g. cutting, poisoning, burning)				
Other				

Self Neglect	Current	Previous History	**Brief Description of the risk, trigger factors and signs**	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, trigger factors and signs**	Are Risk Low, Medium or High
Non-compliance with medication				
Disengagement from mental health services				
Recent bereavement or loss				
Sexual abuse / other abuse				
victimisation				
Financial abuse				
Domestic violence				
Neighbour harassment				
Recent Discharge				

Recent Pregnancy				
Other				

Substance Abuse	Current	Previous History	**Brief Description of the risk, trigger factors and signs**	Are Risk Low, Medium or High
Alcohol misuse				
Drug misuse				
Prescribed drugs				
other				

Assessment completed by:

TITLE		NAME	
ADDRESS			
TELEPHONE			
FAX			
EMAIL			
RELATIONSHIP TO YOU			

Signature:		**Date:**	

STEPPING STONE PROJECTS EQUAL OPPORTUNITIES MONITORING FORM

Please could you respond to this information request positively as it will help us to ensure that our policies, procedures and practices do not inadvertently discriminate against you because of your ethnicity, disability, gender, sexual orientation, age or religion and belief.

ETHNICITY

How would you describe yourself?

Asian or Asian British □ Bangladeshi □ Indian □ Pakistani □ Any other please write here
Black or Black British □ African □ Caribbean □ Any other, please write here
Chinese or other ethnic group □ Chinese □ Any other, please write here
Mixed heritage □ White and Asian □ White and Black African □ White and Black Caribbean □ Any other, please write here
White □ British □ English □ Irish □ Scottish □ Welsh □ Traveller □ Any other, please write here
□ Prefer not to say

DISABILITY

Do you have a physical or mental impairment or long-term health condition □ yes □ no
Is this expected to last, or has it lasted, for a year or longer □ yes □ no
Does this make it difficult for you to do things that most people do on a fairly regular and frequent basis? □ Yes □ No
Do you consider yourself to have a disability or long term health condition? □ Yes □ no

What is the effect or impact of your disability or health condition?

- Prefer not to say
- Mobility
- Mental health
- Learning disability
- Hearing impairment
- Visual impairment
- Progressive disability/chronic illness
- Other, please write here

GENDER

Would you describe yourself as:

- Male
- Female
- transgender
- Prefer not to say

Is this the gender identity the same as the gender you were assigned at birth

- Yes
- No

SEXUAL ORIENTATION

What is your sexual orientation?

- Bisexual
- Gay man
- Gay woman/Lesbian
- Heterosexual/straight
- Other
- Prefer not to say

AGE

What is your date of birth?

RELIGION AND BELIEF

Please tick the box which best describes you:

- Buddhist
- Christian
- Hindu
- Jew
- Muslim
- Sikh
- Other religion or belief (please state)
- No religion
- Prefer not to say

Thank you for your time, this information will only be used to monitoring the accessibility of our services and to ensure continuous improvement.