## STEPPING STONE PROJECT

## Referral

**AND**

**Risk Assessment**

**Form**



**Burnley Accommodation Service and Lancashire Dispersed Housing**

**Stepping Stone Projects**

**Central Referral and Assessment Team**

**PO Box 153**

**Rochdale**

**OL16 1RF**

**Tel: 01706 359600**

**Email:** **CRT@stepping-stone.org.uk**

**Client Details**

|  |  |
| --- | --- |
| **Name** |  |
| **Current Address** |  |
| **Contact number** |  |
| **Date of birth** |  |
| **NI No** |  |
| **Gender** |  |
| **Ethnic origin** |  |
| **Marital status** |  |
| **Dependents** |  |
| **Next of kin** |  |
| **Relationship** |  |
|  **Contact Address** |  |

**Referring Agency Details**

|  |  |
| --- | --- |
| **Date** |  |
| **Referring Agency** |  |
| **Contact Person** |  |
| **Email address** |  |
| **Contact Number** |  |
| **Please state which service you are applying for in order of preference?** | Burnley Accommodation ServiceHyndburn DispersedBurnley DispersedRossendale DispersedPendle Dispersed |

How Long has the client been known to your agency?…………………………...

Is the client aware of this referral being made?……………………………………

Is the client in agreement with this referral being made?…………………………

Have the client ever been in the care of the Local Authority yes/no

If yes, were they in care up to 6 months prior to their 16th birthday? yes/no

Have they ever been a child in need due to being homeless? yes/no

Were they in supported housing when they were under 18? yes/no

If yes, which supported housing project?

When they were at school were they statemented? Yes/no

Did they have a Social Worker? Yes/no

If so, please can you advise their name and if they are still in contact with the worker?

1. Has the client ever used any of the services offered by Stepping-Stone previously?
* Yes
* No
1. If YES which services have they used and who was their Resettlement Worker or Floating Support Worker?
2. What do you think the applicant needs support with?

Please explain what specific issues the client has been experiencing and how you feel Stepping Stone could assist?

**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

|  |
| --- |
| Is the applicant (please tick one of the following)  |
| Working full time  |  | On Job Seekers Allowance |  |
| Working part time |  | On Income Support |  |
| Student |  | On ESA |  |
| On Universal Credit |  | None of the above |  |
| Other (please state) |  |  |

|  |
| --- |
| Please state how much income the applicant has, and from what source  |
| **Source of Income** | **Weekly/ Fortnightly/ Monthly** | **Amount** |
|  |  |  |

Does the client have proof of identify? Yes/no

Does the client have proof of income? Yes/no

Does the client have a history of? Please tick

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Current** | **Past** | **Agency Contact Details** |
| **Drug Misuse** |  |  |  |
| **Alcohol Abuse** |  |  |  |
| **Mental Health** |  |  |  |
| **Violence** |  |  |  |
| **Physical Health Problems** |  |  |  |
| **Learning Difficulties** |  |  |  |
| **Learning Disabilities** |  |  |  |

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

Does the client have any convictions relating to? Please tick

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **N/K** | **Outcome/Sentence** |
| **Arson** |  |  |  |  |
| **Assault** |  |  |  |  |
| **Burglary** |  |  |  |  |
| **Criminal Damage** |  |  |  |  |
| **Drugs** |  |  |  |  |
| **Sexual Offences** |  |  |  |  |
| **Theft** |  |  |  |  |
| **Violence** |  |  |  |  |
| **Others****Please State** |  |  |  |  |

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

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**Joint working**

Will you still be providing some support to the client if they are accepted onto Stepping Stone Project Service?

* Yes
* No

If yes, how frequently would you like to liaise with our support staff and which means of communication would you prefer?

Weekly

Monthly

Quarterly

Six monthly

As required

Letter

Email

Telephone

Text

Meeting

Would it be beneficial to agree a joint support plan, between our two organisations and the client (if they are in agreement), to prevent duplication of work and reduce confusion?

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

* letter
* telephone
* text
* email

Date and Signature of person making the referral

Signature:

Print Name:

Capacity:

Date:

**PLEASE NOTE: THIS REFERRAL CANNOT BE ACCEPTED UNLESS SIGNED BY THE CLIENT BELOW.**

**I agree that I have read the above form and that i consent to THE personal details being sent to STEPPING STONE PROJECTS to support my application.**

**PLEASE TICK IF AGRRED**

**I AGREE THAT STEPPING STONE PROJECTS CAN INFORM THE ORGANISATION THAT HAS COMPLETED THIS FORM WITH ME OF THE OUTCOME OF THIS REFERRAL AND THE DETAILS OF ANY SUPPORT OR HOUSING THAT IS PROVIDED.**

**Please TICk IF AFGREED**

**YOUR PERSONAL DETAILS WILL BE KEPT CONFIDENTIAL AND NOT SHARED WITH ANYONE else WITHOUT YOUR CONSENT, UNLESS WE ARE LEGALLY OBLIGED TO DO SO.**

**further information about how the bond board uses your personal information can be found IN A PRIVACY NOTICE on STEPPING STONE PROJECTS WEBSITE: www.stepping-stone.org.uk IN THE ‘privacy’ SECTION.**

SIGNATURE OF APPLICANT

DATE

**STEPPING-STONE PROJECT**

#  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 |  |  |  |  |
| 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 |  |

|  |
| --- |
| **what PRACTICAL/POSITIVE MEASURES CAN BE PUT INPLACE be to MINIMISE THE RISK(S)?** Visits in pairs/gender specific worker/office appointment only/only visit at a set time/leave if under the influence of a substance, behavioural contract etc. |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature:** |  | **Date:** |  |

**STEPPING STONE PROJECT 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
* Jewish
* 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.