

NOTTINGHAM CITY FLOATING SUPPORT CENTRAL ACCESS POINT

Referral / Application Form

The Nottingham City Floating Support Central Access Point is the initial contact point for referrals and applications to specialist drug, mental health, teenage parent, alcohol and general floating support services across the city.

To meet our Criteria:

- All applicants must be 16 years of age or over
- Living in Nottingham
- In need of their own accommodation, moving to their own accommodation or living in their own accommodation
- The person being referred must be aware and in agreement.

If you require a floating support service please complete this form as fully as you can and return it to **The Central Access Point, Framework, Maville House, Beech Avenue, Nottingham NG7 7LS** or fax it to us on **0115 9789111**.

If you need any help with the form or would prefer to apply for the service over the phone you can contact us for free on **0800 0556184**

You can also text us on **07528 016812** and we'll get back in touch

Once we receive it we will forward it to an appropriate floating support service. They will arrange to see you for an assessment interview so they can discuss the content of this form in more detail. This will give you an opportunity to talk about your support needs and to ask any questions about the service.

Please tick one of the boxes below if you know what service you would like to apply to.

3 Ways A specialist floating support service for with problematic drug use	<input type="checkbox"/>
Home Straight A specialist floating Support Service for people with alcohol problems	<input type="checkbox"/>
Getting Through A specialist floating support service for people with mental health issues	<input type="checkbox"/>
Foundations A specialist floating support service for parents under 21	<input type="checkbox"/>
Key Support A floating support service for single people or couples	<input type="checkbox"/>
Travelling Together A specialist floating support service for Gypsies, Roma or Travellers	<input type="checkbox"/>
Accommodation Finding Service A specialist service for those needing accommodation	<input type="checkbox"/>



PERSONAL DETAILS

Full Name

Phone No

Date of Birth

Gender

Present / Contact Address (If you are moving please give your current address)

Accommodation status

e.g. Homeless, L.A tenant, Home Owner

N.I. Number

(optional)

Pregnant

(If so your estimated due date)

Who else lives with you?

Name	Date of Birth	Relationship	Any Issues / Concerns

1. Are you in the process of being evicted? Yes No (If no please go to Q.2)

If yes, have you:

- a) Received an initial 'Notice' in connection with your home? Yes No
b) Received a 'Claim for Possession' with a hearing date? Yes No
c) Received a 'Notice of Eviction'? Yes No
d) Received any other paperwork? Yes No

(Please give details of paperwork including any dates mentioned):

2. Are you moving? Yes No (If no please go to Q.3)

Do you need support with this move? Yes No (If yes please give details)

(Please include new address)

If you are moving what date does your new tenancy start?

Who will be your new Landlord ?

3. What do you feel you need support with? (Number in priority order as many as you feel are necessary):

- | | | | |
|------------------------------------|--------------------------|--|--------------------------|
| Alcohol issues | <input type="checkbox"/> | Mental Health Issues | <input type="checkbox"/> |
| Drug Issues | <input type="checkbox"/> | Finding Accommodation | <input type="checkbox"/> |
| Eviction | <input type="checkbox"/> | Social / Leisure Interests | <input type="checkbox"/> |
| Repairs | <input type="checkbox"/> | Physical Health / Special Adaptations | <input type="checkbox"/> |
| Budgeting / Debts / Arrears | <input type="checkbox"/> | Harassment | <input type="checkbox"/> |
| Cultural / Faith needs | <input type="checkbox"/> | Benefits | <input type="checkbox"/> |
| Family / Child Concerns | <input type="checkbox"/> | Training and Employment | <input type="checkbox"/> |
| Safety Issues | <input type="checkbox"/> | Dealing with Abuse | <input type="checkbox"/> |
| Independent Living Skills | <input type="checkbox"/> | Getting Involved in the Community | <input type="checkbox"/> |

Details (Please give details for every box ticked. If you have Mental Health Issues please tell us if you have had a formal diagnosis by a GP or other professional and what the diagnosed condition was):

- 1)
2)
3)
Etc

Do you have any other support? (Please include any agencies you have worked with over the last 12 months including your GP, Social Services, Probation, Connexions etc. Also mention anyone else who has supported you like family members/friends. **If you have Mental Health Issues please include the name and contact details of any Care Co-ordinator such as a CPN or Psychiatrist**).

Agency Name	Contact Name	Telephone	Support Provided

Do you have any individual or personal requirements?

(e.g. Are you unavailable at certain times? Do you wish to be supported by another at your assessment? Do you need an interpreter or signer? Would you require a male/ female worker? Do you have mobility difficulties? Is there anything else of importance to you that you wish to tell us?)

(Please specify)

Do you have a preference as to which agency provides your support?

For information on the different floating support providers please phone 0800 0556184

(Please be aware that specifying an agency may effect the length of time it takes you to receive support)

RISK ASSESSMENT

We ask all referring agencies and self applicants to complete a risk assessment and to include it along with the rest of this form.

If your agency has an up-to-date statutory risk assessment please include that with the referral / application form, if not please answer the questions below.

Please include information based upon your own work with the applicant, as well as any known history. If any of the information you pass on to us needs further clarification, please use the end of the form to pass on your concerns.

If you are applying yourself then we will contact someone who knows you to complete the risk assessment. (e.g. a social worker, probation officer or support worker)

We request that you involve your client in this process wherever possible, unless to do so would; in your opinion, increase the potential risk(s) posed.

Does your organisation carry out Statutory Risk Assessments?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
If Yes , is the most recent Risk Assessment attached?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If you answered **NO** or you are unable to provide a statutory Risk Assessment please complete the following Risk Assessment as fully as you can.

Please note that we will be unable to process this referral without a Risk Assessment.

DANGEROUS BEHAVIOUR	Yes	No		Yes	No
Known incidents of violence	<input type="checkbox"/>	<input type="checkbox"/>	Sexual assault / exposure	<input type="checkbox"/>	<input type="checkbox"/>
If Yes , to whom?					
Staff <input type="checkbox"/> Public <input type="checkbox"/>			Anger management / impulsive behaviour	<input type="checkbox"/>	<input type="checkbox"/>
Family <input type="checkbox"/> Friends/Associates <input type="checkbox"/>			Known danger to Children	<input type="checkbox"/>	<input type="checkbox"/>
Severity of incidents					
No Issue <input type="checkbox"/> Minor injury <input type="checkbox"/>			Abuse / harassment of others	<input type="checkbox"/>	<input type="checkbox"/>
Serious injury <input type="checkbox"/> Death <input type="checkbox"/>			Deliberate damage to property /arson	<input type="checkbox"/>	<input type="checkbox"/>
Occurrence					
Once <input type="checkbox"/> Occasionally <input type="checkbox"/>					

PETS	Yes	No	SUBSTANCE MISUSE	Yes	No
Do they have dog	<input type="checkbox"/>	<input type="checkbox"/>	Drug / alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>

EMOTIONAL / MENTAL HEALTH PROBLEMS	Yes	No		Yes	No
Detained under the Mental Health Act	<input type="checkbox"/>	<input type="checkbox"/>	Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Known history of suicide attempts	<input type="checkbox"/>	<input type="checkbox"/>	Dual Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
History of self harm	<input type="checkbox"/>	<input type="checkbox"/>			

SELF CARE / RISK FROM OTHERS	Yes	No		Yes	No
History of serious self-neglect	<input type="checkbox"/>	<input type="checkbox"/>	History of being harassed	<input type="checkbox"/>	<input type="checkbox"/>
History of being abused / exploited	<input type="checkbox"/>	<input type="checkbox"/>	Accidental harm (e.g. kitchen fires, careless smoking)	<input type="checkbox"/>	<input type="checkbox"/>
History of domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>			
Physical Health Issues	<input type="checkbox"/>	<input type="checkbox"/>			

RISK FROM ASSOCIATES	Yes	No		Yes	No
Is there a known risk from friends or family	<input type="checkbox"/>	<input type="checkbox"/>	Are these people regular visitors	<input type="checkbox"/>	<input type="checkbox"/>
Do any of these people live in the property	<input type="checkbox"/>	<input type="checkbox"/>			

If you have ticked **YES** to any of the questions please give a brief outline of behaviour / incidents. Please indicate any work your organisation has carried out with the individual that relates to risk or any work that you or your client has agreed to carry out in the future.

(Please provide full details)

DECLARATIONS

Applicants:

I agree that this referral/application and any information provided with it can be sent to any floating support provider deemed appropriate by the Central Access Point and I give consent for information related to my risk assessment to be discussed with and requested from any relevant third party.

Name of Applicant – signed/typed: _____ **Please tick box to indicate consent if typed:**

Referrers: (N.B. Please ask applicant to complete the above if they are present):

Full Name and contact details of referrer: _____

Relationship to applicant and length of time working with them: _____

I/we confirm that the person being referred is aware of this referral/ application and they give consent to it being made. I/we and they give consent for this referral/application and any information provided with it to be sent to any floating support provider deemed appropriate by the Central Access Point and also give permission for any information relating to the risk assessment to be discussed with and requested from any relevant third party.

Name of Referrer – signed/typed: _____ **Please tick box to indicate consent if typed:**

Telephone applications taken by CAP:

Name and position of worker completing form: _____

I confirm that I have explained to the individual or organisation making this referral that, by making this telephone application, they confirm that they (and, if another, the person being referred) are aware of the referral and consent to it being made. They also confirm that they (and, if another, the person being referred) consent for this referral/application and any information provided with it to be sent to any floating support provider deemed appropriate by the Central Access Point and give permission for any information relating to the risk assessment to be discussed with and requested from any relevant third party.

Name of (Worker – signed/typed: _____ **Please tick box to indicate confirmation if typed:**

Date: _____

EQUAL OPPORTUNITIES

Our Partnership celebrates diversity and promotes a culture where differences between people are respected and valued. To help us ensure that we do this effectively, please provide the information requested below in relation to the applicant.

The information will be treated in the strictest confidence. This information will not affect your application.

ETHNIC ORIGIN:			
Asian/Asian British		Mixed	
Bangladeshi	<input type="checkbox"/>	White and Asian	<input type="checkbox"/>
Indian	<input type="checkbox"/>	White and Black African	<input type="checkbox"/>
Pakistani	<input type="checkbox"/>	White and Black Caribbean	<input type="checkbox"/>
Other	<input type="checkbox"/>	Other	<input type="checkbox"/>
Please Specify		Please Specify	
Black/Black British		White	
African	<input type="checkbox"/>	British	<input type="checkbox"/>
Caribbean	<input type="checkbox"/>	Irish	<input type="checkbox"/>
Other	<input type="checkbox"/>	Other	<input type="checkbox"/>
Please Specify		Please specify	
Chinese		Other Ethnic Group	
Chinese	<input type="checkbox"/>	Other	<input type="checkbox"/>
Other	<input type="checkbox"/>	Please specify:	
Please Specify			
LANGUAGE			
What is your first language?			
Do you need an interpreter?			
RELIGION/ BELIEF:			
Please Specify(and mention any relevant requirements):			
DISABILITY:			
The Disability Discrimination Act (1995) describes a disability as “a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day-to-day activities”.			
Would you consider yourself disabled under this definition? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Please specify(and mention any relevant requirements):			
GENDER:			
Please specify:			

OFFICE / MONITORING USE ONLY

Date referral received.....

Service User ID Number.....

Agency referral allocated to.....

Date of allocation to agency.....