Housing Resettlement and Floating Support Service – Referral

Please ensure you fully complete all parts of this form

|  |
| --- |
| Client name: |
| Current Address: |
| Email: | Contact No.s: |
| Accommodation type: e.g. rented, hostel, council, private | H:M: |
| NI Number: | Age: | Date moved in: |
| D.o.B: | Gender: |

|  |  |  |
| --- | --- | --- |
| Can you tell us if the client has ever: | Yes | No |
| Been convicted of a violent or sexual offence? |  |  |
| Misused alcohol, drugs or been subject to a drug treatment order? |  |  |
| Been asked to sign an Acceptable Behaviour Contract (ABC) or been given an Anti-Social Behaviour Order (ASBO)? |  |  |
| Been treated for any mental health conditions or sectioned under the Mental Health ACT? |  |  |
| Self-harmed (including overdose attempts)? |  |  |
| Are any of your behaviours a risk to yourself or others? |  |  |

If you ticked YES to any of the above please provide details, and approximate dates:

If you are being referred through an agency please complete the following:

|  |
| --- |
| Name of referral agency: |
| Name of referrer: | Date Referred: |
| Contact no.: | Mobile no.: |
| Email address: |



 Why do you feel you need support? e.g. Housing issues, financial issues, life skills etc.

Referral form declarations: The Resettlement and Floating Support Team are

bound by the Data Protection Act. This means your information will be stored

securely, and not passed onto anyone else without your consent.

|  |  |  |
| --- | --- | --- |
|  | Yes | No |
| Do you consent to the information you provide being shared with others involved in your support? |  |  |
| Do you consent to us contacting or referring you to other agencies in relation to your support needs and to working on your agreed support plan? |  |  |
| Your signature:Date: |  |  |

Please ensure this form is returned to The Resettlement and Floating Support Team (Referrals), Housing, Swindon Borough Council, Civic Offices, Euclid Street, Swindon, SN1 2JH

Additional Information

|  |
| --- |
| GP Name and Surgery address: |
| Contact number: |
| Other contact:Person/next of kin (optional) |
| Other House Members: |
| Income details: |

Details of other agencies involved

|  |
| --- |
| Agency name: |
| Contact name and number: |

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| --- |
| Agency name: |
| Contact name and number: |

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| Agency name: |
| Contact name and number: |

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| Agency name: |
| Contact name and number: |

 If we are unable to support you, we will aim to support you finding an agency that can.

Is there anyone you would like to be contacted in the event of an emergency?

 Support Plan

To be completed between client and Officer at the first visit.

Resettlement and Floating Support Service

Support Plan no.: Date:

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| --- | --- |
| Support needs: | Action Required |
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I would like a copy of my support/action plan Yes No