



Appendix 2

Guidance on How to Complete the Floating Support Referral Form

1. Applicant's Details:

Please provide as much information as possible, including National Insurance number – this is used to track service users that are not open to Social Services. If the service user is known to Social Services please provide GENIS number

2. Referred By:

When completing this form please ensure that the name of the referrer, organisation, address, postcode and telephone number is entered. If the referral is made by a member of SSD then you will need to record whether the service user meets SSD FACS (Fair Access to Care Services) criteria. If yes, is the need for a Housing related support part of a Care Package or not?

3. Service User consent:

A referral will only be accepted if it is clear that the service user knows and agrees to be referred. For "informed consent" to be valid it needs to be "expressed"- this means either written or verbal. Provided the referrer has explained what the information will be used for (so that the service user is "informed"), you can then record the fact that the service user/tenant consented to the referral verbally over the phone. The signature of the service user would not be needed in these circumstances. **Informal consent: The Supporting People Floating Support referral form will be used to share information contained within the form with Housing Providers (Including Borough/District Councils, LSVTs, Floating Support Providers, Social Services and the Supporting People Team to enable us to set up a Floating Support service for you). You should also be aware that YOUR LANDLORD WILL BE CONTACTED TO NOTIFY THEM OF SUPPORT PROVISION. If you do not wish for this information to be shared we will not be able to process your referral.**

Service User signature:

Signature of the applicant may not always be possible to obtain, especially if taking a referral over the telephone. The Floating Support Service Provider will obtain applicant's signature at the later date (when the applicant is allocated to a floating support service).

4. Current Accommodation:

Please enter the type of accommodation where the applicant is currently living.

5. Tenure of Property

Please tick tenure of property and write the landlord name (where applicable) against the landlord type

6a. Primary Client Group

Please tick ONLY ONE box for the primary client group

6b. Secondary Client Group

Please tick ONLY ONE box for the secondary client group. Any other information concerning the other needs of the client should be entered in the space provided.

7. Background Information/Priorities

Please tick as many boxes as necessary

8. Description of Support Required

Please tick the appropriate boxes to indicate the support requirements. This information is mandatory because specific types of Floating Support Services are provided in response to needs of a specific service user group. This is essential to avoid inappropriate referrals.

9. The approximate hours of Support required per week

Please tick the approximate number of support hours the service user requires per week. If over 3 hours please state the estimated number of hours required. (Even if this is only for an interim period of time)

10. Support Provider

If the service user has requested a particular service provider to deliver their support please write the name of the provider in the space allocated. If another provider is allocated to a service user (even on an interim measure) the service user will be notified before the assessment takes place, to ensure they accept an alternative support provider

11. Is there involvement from any other professionals?

Are there any other professionals involved with the service user? If so who are they? Which organisation do they represent? Please provide their telephone number/contact details.

12.a Risk issues:

If issues relating to risk are known it is essential that all details be provided.

12.b Previous Support

Has the service user previously had a Floating Support Service during the last 2 years?

13. Referrer's signature:

Please ensure that referral is signed and dated by the person making this referral.

EM Monitoring Form:

This question is about ethnicity, not nationality. On occasions where it is impossible to determine ethnic origin please tick the "other" box and specify unknown.

General Information

FLOATING SUPPORT SERVICES ARE PROVIDED FOR A MAXIMUM OF 2 YEARS – ANY SERVICE GOING OVER THE 2 YEAR PERIOD WILL BE CONSIDERED ON AN INDIVIDUAL BASIS BY THE SUPPORTING PEOPLE TEAM.

Supporting People Floating Support Services **do not** undertake the following tasks:

- Personal Care
- Shopping
- Domiciliary and Home Care
- Health Care
- Therapeutic/Intensive Behaviour Management
- Rehabilitation after Illness / Required Disability
- Rehabilitation and Specialist Counselling
- Help with Transport / Mobility
- Home Adaptations to Improve Accessibility
- Regular Maintenance Services
- Training Courses
- Crèche Facilities
- Rough Sleeper Services
- Actual Handyperson Services
- Decorating Services
- Gardening Schemes
- Accompanying service users on a frequent basis to hospital/doctors/other specialist appointments

NB: Floating Support Services are provided free of charge to the service user except in circumstances where the service holds a subsidy contract (this will mainly apply to some older person's services).

SUPPORTING PEOPLE REFERRAL FORM for FLOATING SUPPORT SERVICES

1. Applicant's Details:

Title:

Surname:

Date of Birth:

Forenames:

Address:

National Insurance No:

Social Services No:

Postcode:

Telephone No:

2. Referred By:

Contact Name:

Telephone No:

Organisation:

Address:

Date completing form:

Email Address:

If referral is made by Social Services (SSD) staff (please tick boxes below)

Does this service user meet SSD criteria? Yes No

If yes: Is this Housing Related support part of a Care Package
Not part of a Care Package

IF THIS SECTION IS NOT COMPLETED THE FORM WILL BE RETURNED TO THE REFERRER

3. Service User Consent: Please see Statement which **must** be read out when taking a referral over the telephone- **for the Informal consent statement see page 1, point 3.** Please tick boxes below.

Does the Service User know this referral is being made?

Yes No

Have they agreed to it?

Yes No

Has the Informal consent statement been read out to the Service User?

Yes No

***Service User: I consent to the information provided on this form being shared with the Supporting People Team and relevant parties who provide me with housing related support.**

Signature:

Date:

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4. Current Accommodation: (please a tick box)			
	Tick		Tick
House/Flat		Hostel	
Bungalow		Supported Housing	
Bedsit		Nursing/Residential Care	
Sheltered		Lodging with Parents/Relatives/Friends	
Extra care Sheltered		Bed and Breakfast	
Refuge		Temporary Accommodation	
Other (please specify)			

5. Tenure of Property (please put the name of the landlord where applicable)	
Council Tenant	
Private Rented	
Owner Occupier	
Voluntary Sector	
Charitable Organisation	
Housing Association	

6a. <u>Primary</u> Service User Group:(please tick ONE box ONLY)			
	Tick		Tick
Learning Disabilities		Alcohol/Drug Problems (delete as applicable)	
Mental Health Problems		Young Person at Risk	
Sensory/Physical Disability		Young Person Leaving Care	
Teenage Parent (s)		Refugees / Asylum Seekers	
Older Person with Support Needs		People with HIV/Aids	
People at Risk or Exposed to Domestic Violence		Offenders/at Risk of Offending	
Single Homeless/Families with Support Needs		Complex Needs/Other	

6b. <u>Secondary</u> Service User Group: (Please tick ONE box ONLY)			
	Tick		Tick
Learning Disabilities		Alcohol/Drug Problems (delete as applicable)	
Mental Health Problems		Young Person at Risk	
Sensory/Physical Disability		Young Person Leaving Care	
Teenage Parent (s)		Refugees / Asylum Seekers	
Older Person with Support Needs		People with HIV/Aids	
People at Risk or Exposed to Domestic Violence		Offenders/at Risk of Offending	
Single Homeless/Families with Support Needs		Complex Needs/Other	

<p>Please provide any other information regarding the client group</p>

7. Background Information/Priorities: (Please tick ONLY those that apply)	
	Tick
1) The Service User is likely to lose their tenancy within 8 weeks through eviction or re-possession order	
2) The Service User is moving from parents home / temporary / supported / institutional accommodation to independent accommodation	
3) The Service User is known to have issues relating to domestic or other forms of violence	
4) The Service User displays offending behaviour (including anti social behaviour)	
5) Does the Service User have any dependants or living with parents/friends/relatives etc (Please specify)	

8. Description of support required. Please tick all those that are relevant.			
	Tick		Tick
Immediate risk of Domestic Violence / Harassment		Help in managing finances and welfare benefit claims	
Offending Behaviour, Anti-social behaviour, Racial Harassment and neighbour disputes		Setting up a new dwelling	
Rent or Mortgage Arrears (Delete as applicable)		Help in gaining access to other services	
Threat of Eviction – due to Arrears or Other		Unable to maintain / neglect of property	
Young person (under 18 years)		Advice, Advocacy and Liaison	
Rough Sleeper / transition to new tenancy		Neglect of self or property	
Discharge from Hospital / Prison (Please provide expected date of release)		The Service User has either been through the Single Agency Assessment (SAA) or Joint Assessment Referral Process (JARP/JARS)	
Life or Parenting Skills (Delete as applicable)			
Other – Please specify			

9. Approximate number of support hours required <u>per week</u>:			
	Tick		Tick
30 minutes		Over 1.5 Hours to 2 Hours	
Up to One Hour		Over 2 Hours to 2.5 Hours	
Between 1 Hour and 1.5 Hours		Over 2.5 Hours to 3 Hours	
Over 3 Hours – Please state number of hours required per week:			

10. Has the Service User requested a particular Service Provider to provide their support?
If so please give the name of the Provider:

11. Are there any other Professionals currently working with this Service User? (Please tick all those that apply)

Social Worker		Domiciliary Care	
Community Psychiatric Nurse		District Nurse	
Occupational Therapist			

Other Professional Worker (Please state)

Please provide contact details for the Professional:

12a. Risk issues: (this information may not always be known and is for office use only)

Does the Tenant/Service User present a known risk to her/ himself or others?

Yes No

If yes, please give details:

12b. Has this service user received Floating Support Services during the last 2 years? If yes, please give details:

13. Referrer's signature:

Date:

For further information about this form please contact The Supporting People Team on 01622 694953 or E-mail 'supportingpeopleteam@kent.gov.uk'

To return this form please post to: Kent County Council, Supporting People Team, Sessions House, Room 4.02, County Hall, Maidstone, Kent, ME15 1XQ - fax on 01622 694746 or email to 'supportingpeopleteam@kent.gov.uk'

For Supporting People / Housing Department office use only (please do not complete):

Points Awarded:

Date received:

Date entered onto waiting list:

Date allocated to the Floating support service/ Provider Name/Service name:

Reason for referral not being accepted and action taken:

Ethnic Minority Monitoring Form

The Supporting People are committed to providing services that are accessible to all service users regardless of race, gender or ethnicity.

The information supplied below is strictly for gathering data to monitor service provision and will remain strictly confidential.

Ethnic Origin – Please tick one box only

White	British	<input type="checkbox"/>	Asian or	Indian	<input type="checkbox"/>
	Irish	<input type="checkbox"/>		Asian	Pakistani
	Gipsy/Travellers	<input type="checkbox"/>	British	Bangladeshi	
	<input type="checkbox"/>				
	Other White background (please specify)			Other Asian background (please specify)	
_____			_____		
Mixed	White & Black Caribbean	<input type="checkbox"/>	Black or	Caribbean	<input type="checkbox"/>
	White & Black African	<input type="checkbox"/>		Black	African
	White & Asian	<input type="checkbox"/>	British	Other black background (please specify)	
	other mixed background (please specify)				
_____			_____		
Chinese	Chinese	<input type="checkbox"/>			
	Any other ethnic background	<input type="checkbox"/>	(please specify) _____		

Gender, please tick

Male	<input type="checkbox"/>
Female	<input type="checkbox"/>
Transgender	<input type="checkbox"/>
