**Mental Health Housing Related Support Services**

**Referral Form**

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| **Area** | Richmondshire | |  | Hambleton | |  | Scarborough | | | | |  | | | Ryedale |  | |
| **Type of Support** | | Supported Accommodation | | | | | |  | | Floating Support | | | | | |  | |
| **Individual**  Title:  Name:  Address:  Postcode:  Contact number:  Date of Birth:  Age: | | | | | **Referrer**  Date request made:  Name:  Role:  Organisation:  Address:  Contact number:  Email:  Is the customer aware of the referral?  Yes/ No | | | | | | | | | | | | |
| **Type of accommodation Currently Occupied** | | | | | Housing Association | | | |  | | Lease | |  | Home Owner | | |  |
| Local Authority | | | |  | | Private Rent | |  | Other Please state: | | | |
| Hospital | | | |  | | Residential Care | |  |

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| **Eligibility Criteria**  Please highlight | | | |
| Over the age of 18 years | Yes/ No | Has a mental health Issue | Yes/ No |
| Has a housing Support need | Yes/ No | Has the potential to move on to independent living within 1 year | Yes/ No |
| Has a willingness to engage with support | Yes/ No | Currently resides in the District/ Brough Local Authority area | Yes/ No |
| Does not pose any unreasonable risk to other individuals or property | Yes/ No |  |  |

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| Please let us know if you require this information or any future communications, documents, or letters in the following formats | | | |
| Large Print  Yes/ No | Braille  Yes/ No | Audio Tape  Yes/ No | CD  Yes/ No |
| Language other than English Yes/ No  Which Language | | | |

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| **Mental Health Need**  Please outline the customers Mental health Need: |

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| **Housing Support Need**  Please identify type of support required: |

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| **Health and Safety Concerns at Current Accommodation**  Pets:  Infestations:  Excessive household waste:  Rubbish:  Needles:  Bottles:  Hoarding:  Other: |

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| **Is the Customer a risk to self or others? Yes/ No**  Please comment: |

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| **Please identify any services, names and contact details that are currently involved with the customer:** |

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| **Does the customer have?:**  Care Plan **Yes /No**  Risk Assessment **Yes/ No**  Are they up to date **Yes/ No**  Please include a copy of the most recent Care Plan and Risk Assessment  Does the Customer have an up to date Social needs Assessment **Yes/ No** |

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| **Any further information:** |

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| **Please return to:**  [MentalHealthEnquires@broadacres.org.uk](mailto:MentalHealthEnquires@broadacres.org.uk)  Broadacres Housing Association  FREEPOST RRBZ-TATA-BYHL  Mental health service  Broadacres House  Mount view  Standard Way  Northallerton  North Yorkshire  DL6 2YD  Tel: 01609 767900 | |
| Referral made by: | Date |
| Referral received by: | Date: |