**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 PrintYes/ No  | BrailleYes/ No | Audio TapeYes/ No  | CDYes/ 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.ukBroadacres Housing AssociationFREEPOST RRBZ-TATA-BYHLMental health serviceBroadacres HouseMount viewStandard WayNorthallertonNorth YorkshireDL6 2YDTel: 01609 767900 |
| Referral made by: | Date  |
| Referral received by: | Date: |