**INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE**

|  |  |  |  |
| --- | --- | --- | --- |
| **What type of supported Living service is being requested? (Please select)**  A long term supported Living service  A short break service  Home form hospital  Day time services  Just Next Door (semi-independent living) | | | |
| Last name |  | Title |  |
| Forename (s) |  | Like to be known as |  |
| Current Address |  | Gender |  |
| DOB |  |
| Telephone |  | Nat Insurance no |  |
| NHS no |  |
| Next of Kin//carer |  | Social / Care Worker |  |
| Name |  | Name |  |
| Relationship |  | Team |  |
| Address |  | Address |  |
| Telephone |  | Telephone |  |
| Email |  | Email |  |
| GP name or Medical Centre contact details (if known) | |  | |
| Who is the main correspondent for the purposes of this referral? Please insert name | |  | |
| Telephone /Email | |  | |

**INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE**

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| --- | --- |
| **Please tick any boxes that describe the person’s current situation:**  Is a young person in transition from foster care  Is a currently living at home with parents/family  Is currently in a residential school or college  Is currently living alone  Is currently living in a residential care home  Is currently living in a supported living tenancy  Is currently assessed under a section of the Mental Health Act (section 2,3 or 117)  Health/Home from Hospital  Other (please describe below):  Click or tap here to enter text. | |
| **Please tick the statement that relates to the PRIORITY NEEDS for the person who wants the service- this is to identify the MAIN support need; other needs can be identified below:** | |
| Learning disability | Is a person over age 60 |
| Mental health issues | Physical disabilities |
| Dementia | Sight impairment/is non sighted |
| Hearing impairment/def | Acquired brain injury |
| Autism | Reablement for hospital |
| Substance misuse | other: Click or tap here to enter text. |

*If this is a Home from Hospital referral, please complete the section below. If not, continue to next section.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of hospital | |  | | | |
| Name of ward | |  | Phone number |  | |
| Other professionals involved | | | Professionals contact details | | |
|  | | |  | | |
| Intermediate Care Team/Discharge team contact details | | | | | |
|  | | | | | |
| Estimated date of discharge |  | | Is this person medically fit for discharge? | |  |
| Is there a discharge plan in place:  Yes  No  **Please enclose with the referral** | | | | | |

**INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please describe the ethnic origin of the person requesting the service** | | | | |
| **White** | **Black or Black British** | **Asian or Asian British** | **Mixed** | **Other ethnic group** |
| British | Caribbean | Indian | White and black Caribbean | Chinese |
| Irish | African | Pakistani | White and Black African | Any other ethnic group |
| Any other white background | Any other black background | Bangladeshi | White and Asian |  |
| Click or tap here to enter text. | Click or tap here to enter text. | Any other Asian background  Click or tap here to enter text. | Any other mixed background | Click or tap here to enter text. |

**FURTHER INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE**

|  |  |
| --- | --- |
| Where does the person wish to live (for long term service requests). Please specify any geographical areas that would be considered/would definitely not be considered. | |
|  | |
| For Short breaks/Home from Hospital: What areas would the person consider travelling to for a Short break/Home from Hospital (including, Derby, Nottingham, Leicester and Staffordshire) | |
|  | |
| How often would the person like short breaks? E.g., one weekend a month. | |
|  | |
| **Ideally what type of household would the person prefer to be in?** | |
| Prefer to be the only person being supported  Would like a household with animals/pets  Prefer a quiet household  No particular preferences | Prefer company of similar age  Do not like cats/dogs  Prefer an active household |
| **Does the person wanting the service have the mental capacity to understand and make a decision about where they live?**  Yes  No | |
| **If not, has a best interest decision meeting been held?**  Yes  No  Please supply any written evidence | |
| **Does the person being supported or the appropriate representative understand how supported living works?**  Yes  No | |
| **If no, can we make contact with them?**  Yes  No | |
| **Are there any complex family issues/relationship/safeguard issues?**  Yes  No  If yes, please supply details: | |

**FURTHER INFORMATION ABOUT THE PERSON CONTINUED**

|  |
| --- |
| **Tell us about the person wanting the service.**  E.g. hobbies and interest weekly routine, family and friends.  The more you can tell us, the more it will help us to find a match within our service.  Please enclose a recent needs assessment/care plan.  Click or tap here to enter text. |
| **What are the main areas of support that the person requires from the service?**  E.g. help with personal care, daily living skills, emotional support.  Click or tap here to enter text. |
| **Does the person have any specific support needs we should take into account in the matching?**  e.g. use of stairs, wheelchair user, mobility aids, specific communication needs, night time needs.  Please list.  Click or tap here to enter text. |
| **Are there any areas of risk to the person or to others around them?**  *Please provide any risk assessments*  Click or tap here to enter text. |
| **Can the person be left alone for any period of time?**  Click or tap here to enter text. |
| Is the person currently taking any medication? Do they have any known allergies?  Please specify.  Click or tap here to enter text. |
| **Any specific dietary requirements? Is a special diet required? Are there any choking risks and are the speech and language team involved?**  Click or tap here to enter text. |
| **Any specific health issues which will need support? (Example-skin integrity concerns)**  Click or tap here to enter text. |

**FURTHER INFORMATION ABOUT THE PERSON CONTINUED**

|  |
| --- |
| **Are there any continence needs?**  Click or tap here to enter text. |
| Other services used by the person (long term placements only)  **Does the person attend any day time / leisure activities that need to be maintained?**  Yes  No  Don’t know  If yes, please give details: Click or tap here to enter text. |
| **Any other information about the person requesting the service?**  Click or tap here to enter text. |

**FUNDING**

|  |
| --- |
| **Who is likely to have funding responsibility for this service?**  Local authority commissioned service  Direct payment / held by who? Please specify below  Self-funded by person/other  Health Authority  Other, please specify:  Click or tap here to enter text. |
| **Is any funding already agreed in principle to meet this service request?**  Yes  No  If yes, please give details  Click or tap here to enter text.  The cost of the service will be determined based on the support needs of the individual |
| **Is the person currently funded under section 117 of the Mental Health Act?**  Yes  No  Not known |
| **Is the person currently making any contribution to the cost of any of their care?**  Yes  No  If yes, how much and what frequency?  Click or tap here to enter text. |

**THE PERSON’S FINANCIAL SITUATION**

|  |  |  |  |
| --- | --- | --- | --- |
| **Does anyone act as?** (*tick box*)  Appointee  Corporate Appointee  Deputy  LPA | | | |
| **Details of anyone appointed to manage the person’s financial/personal affairs on their behalf** | | | |
| **Name** |  | **Relationship** |  |
| **Address** |  | **Telephone** |  |
| **Email** |  |
| **Does the person requiring the service have a mobility funded vehicle?**  Yes  No | | | |
| **Does a financial capacity assessment need to be completed?**  Yes  No  If yes, please submit the assessment | | | |
| **Does the person have any paid or voluntary employment?**  Yes  No  Don’t know  If yes, please give details  Click or tap here to enter text. | | | |
| **Does the person attend college/educational activity**  Yes  No  Don’t know | | | |

**THE PERSON’S FINANCIAL SITUATION**

We can not progress the referral without some financial information, so please complete as fully as possible.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **FOR LONG TERM SERVICE ONLY**  Please list the service user’s current benefits and sources of income and provide proof. | | Amount £ | How often | Any further information |
| Universal Credit | | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Does that include household costs? | | Yes  No | | |
| Employment Support Allowance | |  |  |  |
| Income Support | |  |  |  |
| Severe Disablement Allowance | |  |  |  |
| Personal Independence  Payment | Daily |  |  |  |
| Mobility |  |  |  |
| Disability Living allowance | Care |  |  |  |
| Mobility |  |  |  |
| Pension Credit | |  |  |  |
| State Retirement pension | |  |  |  |
| Pension – Occupational | |  |  |  |
| Other Income | |  |  |  |
| Earnings from paid employment | |  |  |  |

|  |
| --- |
| **The person completing the form needs to sign here:**  Signature:…………………………………………………………………………………………………………………………………  Date:Click or tap here to enter text.  Print Name: Click or tap here to enter text.  Relationship to person: Click or tap here to enter text.  It is important that the person requesting the service from Right Care Service is aware that the information on this form will be shared with selective staff and some carers in order to provide a service that will meet the needs of the person. Please make sure this has been discussed and is understood by the person as appropriate.  **Signature of person requesting service (where applicable)**  Click or tap here to enter text. ………………………………………………………………. |
| **Attachments – the more information you can send us find the correct placement for the person.**  **Please tick any further information/documentation that is attached.**  Current or very recent needs assessment  Current or very recent care plan or person-centred plan  Current or very recent risk assessment  Other additional information  MCA/FCA assessments  Hospital discharge plan  Benefits information |

**RETURNS**

Please send your completed referral form and any additional information by email to

[referrals@rightcareservices.co.uk](mailto:referrals@rightcareservices.co.uk)