Support Assessment Referral Form (SARF)

Please save the SARF with the naming convention CLIENTINITIALS\_DDMMMYY

(E.G JB\_01APR2016)

Please complete this form for all referrals - **The onus for ensuring that the correct supporting documentation is attached to this form is with the referrer;** failure to attach or provide the correct documentation may result in delays processing the application / a rejection of the application.

|  |
| --- |
| **SARF – please complete all sections, if a section is not relevant please mark as NA instead of leaving blank.**  |
| SARF completed by: |
| Staff Name: |  | Date Completed: |  |
| Service Name |  | Contact No: |  |
| Email: |  |

|  |  |
| --- | --- |
| Clients Full Name: |  |
| Current Address: |  |
| Mobile No: |  |
| Email Address: |  |
| NI No: |  |
| Gender: |  | DOB & Age: |  |
| Nationality: |  | Ethnic Origin: |  |
| First Language/ Interpreter Needed? |  | If yes (specify language): |  |
| Religion: |  | Sexuality: |  |
| Is client pregnant? |  | Expected Delivery Date |  |
| Is the client in NSNO Hub? If Yes – where? |  | CHAIN No: |  |
| Has the client slept rough in the past? |  |
| Does the client have a pet? (e.g. dog) |  |
| **Next of kin details:** |
| Name: |  | Relationship: |  |
| Address: |  | Tel No: |  |
| **Last settled accommodation prior to homelessness:** |
| Council Property/RSL: |  | Private Rented: |  | With Partner: |  |
| Parental/Family Home: |  | In Care: |  | Other: |  |
| *(If other please specify):* |

1. **Reason for referral –** Can be completed by the applicant or the referring agent (if you are the referring agent please state how long you have worked with the individual and in what capacity)

|  |
| --- |
| * Please explain the reason for referral to supported housing
* Please include the reasons you why you feel that supported housing would be beneficial for you at this time.
 |
|  |
| ***If referral is for an applicant with no local connection to the borough the service is in – please provide reason for placing outside of their local connection (ie. Domestic Abuse, Gang Violence)*** |
|  |

|  |
| --- |
| 1. **Clients Statement:**
 |
| * *What you hope to gain by living in supported accommodation?*
* *What type of accommodation do you feel you need?*
* *What type of support do you feel you need?*
 |
|  |

|  |
| --- |
| 1. **Current Accommodation:**
 |
| Approved Premises: |  | Temporary Accommodation: |  | Hostel: |  |
| NSNO Hub (No 2nd Night Out) |  | Rough Sleeping: |  | Friends/Family: |  |
| Detox Unit: |  | Rehab Unit: |  | Residential Care: |  |
| Prison |  | Assessment Centre: |  | Supported Housing (24 hr) |  |
| Supported Housing (Semi Independent): |  | Supported Housing (Visiting/Floating): |  | Hospital: |  |
| Other |  | *If* ***other*** *or* ***hospital*** *please give details:* |

|  |
| --- |
| **4. Housing History**Please provide details of the clients housing history over the last 5 years. This information should also include details of any time spent in hospital, prison or periods of rough sleeping. Reasons for leaving **MUST** be given (Reasons could include: antisocial behaviour, abandonment, escaping violence, hospital admission, inability to cope, noise nuisance, mobility issues, period in custody, relationship breakdown, rent arrears).  |
| Address *(include accommodation type)* | From | To | Reason for leaving |
|  **From** | **To** | **Address** Please also identify the last settled address  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **5. Support** |
| Primary Support Need (please only check **ONE** box) |
| Asylum Seeking |  | Care Leaver |  | Ex or current Offender |  |
| Learning Disability |  | Mental Health |  | Older Person |  |
| Physical Health |  | Rough sleeping |  | Sex working |  |
| Alcohol Misuse |  | Substance Misuse |  | Young Person |  |
| Dual Diagnosis (Please Specify) |  |
| Fleeing Violence (Please Specify) |  |
| Additional Notes: (need to be aware of perpetrators of violence please include details) |
|  |
| Secondary Support Need (tick as many as appropriate) |
| Alcohol Dependency |  | Care Leaver |  | Drug Dependency |  |
| Offending |  | Financial Problems |  | Older Person |  |
| Learning Disability |  | Young Person |  | Mental Health |  |
| Social Isolation |  | Physical Health |  | Refugee |  |
| Relationship breakdown  |  | Rough sleeping |  | Sex working |  |
| Dual Diagnosis (Please Specify) |  |
| Fleeing Violence (Please Specify) |  |
| Additional Notes: |
|  |

|  |
| --- |
| **6. Substance Use** |
| Alcohol User |  | Drug User |  | Poly User (Both) |  |
|  |
| Is the client abstinent? (Over 3 days) | Yes |  | No |  |
| (How long the client has been abstinent and/or if they have had periods of abstinence in the past. Also give details of how abstinence could be verified – i.e. if client had regular testing or self - reported) |
| Are there any triggers that can result in relapse? |
|  |
| Main Substance: |  | Age first used |  |
| Street illicit |  | Prescribed by GP |  | Prescribed Substance Misuse Service |  |
| Prescribed & illicit |  | Purchased legally |  | Other prescribed |  |
| Frequency of use: |  | Weekly Spend |  |
| Route of Administration |
| Inject |  | Sniff |  | Smoke |  | Oral |  | Other (specify) |  |
|  |
| Second Substance: |  | Age first used |  |
| Street illicit |  | Prescribed by GP |  | Prescribed Substance Misuse Service |  |
| Prescribed & illicit |  | Purchased legally |  | Other prescribed |  |
| Frequency of use: |  | Weekly Spend |  |
| Route of Administration |
| Inject |  | Sniff |  | Smoke |  | Oral |  | Other (specify) |  |
|  |
| Third Substance: |  | Age first used |  |
| Street illicit |  | Prescribed by GP |  | Prescribed Substance Misuse Service |  |
| Prescribed & illicit |  | Purchased legally |  | Other prescribed |  |
| Frequency of use: |  | Weekly Spend |  |
| Route of Administration |
| Inject |  | Sniff |  | Smoke |  | Oral |  | Other (specify) |  |
|  |
| ALCOHOL USE |
|  |
| Alcohol Dependant? | Yes |  | No |  | Age first used |  |
| Details of Alcohol: Type and units: |  |
| Frequency of use: |  | Weekly Spend |  |
| Additional Information: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is the client currently accessing support/treatment? | Yes |  | No |  |
| *If YES please give details including what support they are receiving and how long they have been accessing support/services and also include any contacts within the “support services involved in the clients current support” section):* |
|  |
| How does the client behave when under the influence? |
|  |
| Are there any risks associated with their substance misuse? *(e.g. ASB/overdose/chaotic using practices)* | Yes |  | No |  |
| *(If YES please provide details and add to risk section ):* |

|  |
| --- |
| **7. Mental Health** |
| Mental Health Diagnosis: |  |
| Confirmed by a MH Professional? | Yes |  | No |  |
| Client linked to CMHT? | Yes |  | No |  |
| Additional information regarding support needs and services. (If you check a box please provide details in the additional notes section) |
| Anger management  |  | Anxiety |  | Bipolar |  |
| Care Programme Approach (CPA) |  | Delusional Thoughts |  | Depression |  |
| First Episode Psychosis |  | Forensic Mental Health |  | Home Secretary Restriction Order |  |
| In Hospital |  | On Depot |  | Oral Medication |  |
| Panic/Anxiety Attacks |  | Paranoia |  | Personality Disorder |  |
| Schizophrenia |  | Self-Harm |  | Social Phobia |  |
| Suicide Attempts |  | Suicidal Ideation |  | Receiving outpatient treatment |  |
| Additional Notes |
|  |
| Is the client engaging with mental health services?  | Yes |  | No |  |
| *(If YES please provide details)* |
| Has the client previously been linked to a mental health service? | Yes |  | No |  |
| *(If YES please provide details including dates):* |
| Has the client ever been sectioned? | Yes |  | No |  |
| *(If YES please provide details including date):* |
| Is the client taking medication or engaging in treatment? | Yes |  | No |  |
| *(If YES please provide details including what happens if the client does not take their medication):* |
| Information about Mental Health Medication |
| Name of Medication | Frequency  | Administration Route (e.g. depot/ oral etc.) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Are there specific triggers for the client becoming unwell? *(Please give details)* |
|  |
| What behaviours/signs indicate the client is becoming unwell? *(Please give details)* |
|  |
| Are there any risks associated with their mental health? | Yes |  | No |  |
| *(If YES please provide details and add to risk section ):**e.g. neglect, room management, ASB, violence* |

|  |
| --- |
| **8. Physical Health** |
| Clients current physical health needs *(please include nature and severity of the physical health need)* |
|  |
| Please give details of treatment client is currently receiving *(Please provide details and also include any contacts within the “support services involved in the clients current support” section):* |
|  |
| How is client managing at the moment? |
|  |
| Is the client taking medication? *(please provide details and how long they have been on this medication)* |
|  |
| What happens if the client does not take their medication? |
|  |
| How does their physical health impact on their day to day lives? |
|  |
| Does the client require ground floor accommodation? *(if YES how has this been assessed?)* |
|  |
| Does the client use mobility aids? |
|  |
| Are there any specific requirements in the accommodation with regard to physical health? |
|  |
| Are there any risks associated with their physical health issues? *(If YES rate as high, medium or low)* |
| *(If YES please provide details and add to risk section ):* |
| Is the client in receipt of DLA or PIP? | Yes |  | No |  |
| *(If YES what rate of DLA / PIP are they claiming and is this related to their physical health?)* |
| Is the client using/have they used their DLA / PIP package to provide additional care? | Yes |  | No |  |
| *(If YES please provide details)*  |
| Would the client be willing to use this money for a care package? | Yes |  | No |  |
| *(If NO please provide details)* |
| Any other relevant information: |
|  |

|  |
| --- |
| **9. Offending History** |
| Client linked to Probation or Youth Offending Service? | Yes |  | No |  |
| Please provide worker details *(Include how often the client needs to see this worker)*: |
| Has the client previously been linked to Probation or Youth Offending Service? | Yes |  | No |  |
| *Please provide details of when this was and previous worker details:* |
| Has the client been convicted of any of these offences? |
| Arson  |  | Violence |  | Sexual Offence |  |
| *(If YES please provide details and dates)* |
| Has the client ever been a registered sex offender?  | Yes |  | No |  |
| *(If YES please provide dates)* |
| Is the client known to MAPPA?***(Multi-Agency Public Protection Arrangements)***  | Yes |  | No |  |
| Please indicate offence |  |
| *Please indicate Category/Level for the above offence* |
| Category One: |  | Category Two: |  | Category Three: |  |
| Level One: |  | Level Two: |  | Level Three: |  |
| Is client on any of the following orders?*Please attach any probation/Youth Offending Service documents and also include this information within the “supporting document checklist” section)* |
| Suspended Sentence Order |  | Home Detention Curfew (HDC)/Tag |  |
| Drug Rehabilitation Requirement |  | Anti-Social Behaviour Order (ASBO) |  |
| License  |  | Community Order |  | Referral Order |  |
| Youth Rehabilitation Order |  | Intensive Supervision and Surveillance  |  | Detention and Training Order |  |
| *(If Other please specify)* |
| Date License/Order ends: |  |
| Please list clients offending history including dates, sentences or community orders: |
|  |
| If probation documents are not attached please give reasons: |
|  |

|  |
| --- |
| **10. Support required to live independently** |
|  | Always | Sometimes | Not at all |
| Personal care |  |  |  |
| Accessing other Services |  |  |  |
| Accessing education/training |  |  |  |
| Accessing employment |  |  |  |
| Applying for welfare benefits |  |  |  |
| Paying rent and utility bills |  |  |  |
| Independent living (cooking, cleaning, shopping) |  |  |  |
| Literacy support |  |  |  |
| Language and translation |  |  |  |
| Taking medication |  |  |  |
| Dealing with isolation |  |  |  |
| Engagement with support |  |  |  |
| Spending time with family and friends |  |  |  |
| Looking after children |  |  |  |
| Looking after partner, parent or other family members |  |  |  |
| Cultural or spiritual activities |  |  |  |
| Leisure activities |  |  |  |
| ***If either “always” or “sometimes” is checked, please indicate what support is required:***  |
|  |

|  |
| --- |
| **11. Financial Inclusion** |
| Is the client in receipt of benefits? | YES |  | NO |  |
| *(Please include all benefits and the amounts where known)* |
| Has a claim for benefits been made and a decision pending? | Yes |  | No |  |
| Does the client have a bank account? | Yes |  | No |  |
| Does the client have access to online banking?  | Yes |  | No |  |
| Is the client currently in paid employment? | Yes |  | No |  |
| *If YES, please state the following* * Name of employer
* Length of time in employment
* Hours per week
* How much they earn per week (gross)
 |
| Does the client have any savings | Yes |  | No |  |
| *(If YES please include details)* |
| Does the client have outstanding debt problems? | Yes |  | No |  |
| *(If YES please include details)* |  |
| Has the clients income been affected by changes to benefits? | Yes |  | No |  |
| *(If YES please include details)* |
| Is the client currently paying rent & service charge? | Yes |  | No |  |
| Does the client have any rent/service charge arrears? | Yes |  | No |  |
| *(If YES please include details)* |
| Is there a payment plan in place? | Yes |  | No |  |
| *(If YES please include details and if client is complying)* |

|  |
| --- |
| **12. Support services involved in the clients current support** |
| Name/Type of service (e.g. GP/CMHT/YOS) | Contact Name | Contact details (address/tel./email) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| **13. Employment/Training/Education** |
| Employment/Education/Training/Volunteering | From | To | Reasons for leaving |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **14. Serious Untoward Incidents & Safeguarding** |
| *Please use this space to detail any SUI’s involving this client in the last 3 months and/or whether there are any safeguarding alerts in the last 12 months that may be relevant.* |
|  |

|  |
| --- |
| **15. Clients Legal Status** |
| Client’s country of origin: | British |
| Has the client lived outside of the UK within the last 5 years? | Yes: |  | No: |  |
| (If YES please provide dates and locations) |
| When did the client arrive in the UK? |  |
| Does the client have recourse to public funds? | Yes: |  | No: |  |
| (If YES please give details) |
| What date did client start claiming benefits? |  |
| Does the client have leave to remain? *(Please provide dates and expiry date)* |
| Indefinite |  | Refused |  | Limited |  |
| Are there any conditions attached to their leave to remain? *(Please give details):* |
|  |
| Any other relevant information: |
|  |

**16. Risk summary – please summarise the risks outlined in the assessment, please submit any other relevant risk documentation e.g. SLaM’s risk assessment tools; Care Programme Approach information/OASYS/YOS/CPA/ etc. along with this SARF form.**

|  |  |  |
| --- | --- | --- |
| **Identified Risk type** | **Tick if applicable**  | **Assessment of risk** |
| **Risk to self**  |  |  |
| **Risk to Others** |  |  |
| **Risk of abuse from others** |  |  |
| Schedule 1/Dangerous Offender/MAPPA client |  |  |
| Verbal abuse |  |  |
| Aggressive or intimidating behaviour |  |  |
| Physical aggression/violence |  |  |
| Non-Cooperation with staff |  |  |
| Mental health |  |  |
| Substance misuse |  |  |
| Street activity |  |  |
| Offending or anti-social behaviour |  |  |
| Verbal abuse |  |  |
| Damage to property |  |  |
| History of rape or sexual assault |  |  |
| Accidental fire setting |  |  |
| Arson |  |  |
| Lone working considered unsafe  |  |  |
| Female lone working considered unsafe |  |  |
| Hoarding |  |  |
|  |  |  |

|  |
| --- |
| **16.1 Details of Identified risk** * Please use the space below to specify any risk factors linked to the behaviours identified above
* Please address the frequency, severity and pattern of behaviour
* Include details of last know incident
 |

|  |  |
| --- | --- |
| **16.3: Who is at risk?**(provide details where appropriate in the space provided) | Tick as many as apply |
| Client |  |
| Staff |  |
| Visitors/Neighbours |  |
| Contractors |  |
| Specific individual(s) (specify) |  |
|  |

|  |
| --- |
| **16.4: Risk Assessment Action Plan** |
| Triggers / behaviour to be aware of:   |

|  |
| --- |
| **17. Client Consent** |
| We need to obtain and share information about you with, and from a number of agencies to enable us to assist you effectively.In order to help you access support services, we need your consent to access information about you from other agencies such as Housing Benefit, your GP, YOS, Probation etc… Information that you provide will also be shared with the services that we want to support you.In order to ensure your safety and the safety of others we will also complete a risk assessment which will be shared with any services that we want to provide you with supportInformation will be shared on a need to know basis, where there is a specific and legitimate need to know. |
| I …………………………………………………………………………………………….(print name) have checked the information on this form and agree it is accurate.I understand and consent to the agencies obtaining information about me in order to make a full and accurate assessment of my situation.I understand and consent to the information given to the agencies to be shared with other organisations and services.Signed:……………………………………………………….Date: …………………………………  |
| Witnessed by (Staff signature) | Staff Printed Name | Date |
|  |  |  |

### 18. SUPPORTING DOCUMENTS CHECKLIST

*Items 1 and 2* ***MUST*** *be provided as a minimum*

|  |  |  |
| --- | --- | --- |
|  | **Checklist items** | **Attached** |
| 1 | Proof of identity and nationality (passport, birth certificate) |  |
| 2 | Proof of income (wage slip, welfare benefits) |  |
| 3 | Proof of current address (tenancy agreements, current utility bills) |  |
| 4 | Psychiatric report |  |
| 5 | Latest CPA report |  |
| 6 | Community Care Assessment |  |
| 7 | Occupational Therapy or other Health Assessment |  |
| 8 | Medical Self-Assessment |  |
| 9 | Probation/YOS Summary |  |
| 10 | Other (Please specify) |  |