



Assessor details

Referrals can only be completed by a professional person or professional body who can qualify for the actual need of Exempt Supported Accommodation.

Date of assessment (todays date) *

Day Month Year

Client details

Preferred Title or Client *

Please Select

Client Name *

First Name

Last Name

Clients Middle Name *

Other name (s)/ Known as

Client's date of birth *

Day Month Year

Client Place of birth *

Please Select

Previous Address (Last Known Address) *

Street Address

City

Postal / Zip Code

National Insurance number? *

Client Mobile number *

Please enter a valid phone number.

Email *

example@example.com

Have you been homeless before? *

- ☐ Yes
☐ No

If you have been homeless before, how long for? *

- ☐ Less than a year
☐ 1 - 2 years
☐ 3 - 5 Years
☐ 5 + years

Diversity Monitoring

Communication needs

Please provide details of ailments and medication *

Do these health conditions Impact your daily living? *

- ☐ Yes
☐ No

Please provide details *

Do you have any mental health conditions? *

- ☐ Yes
☐ No

Which of the following mental health conditions do you suffer from *

- ☐ Depression
☐ Generalised Anxiety Disorder
☐ Emotionally Unstable Personality Disorder
☐ Personality Disorder
☐ Eating Disorders
☐ Other

Are you prescribed medication? *

- ☐ Yes
☐ No

Which medication are you prescribed?

Name of Drug

Dosage

How many times per day

1			
2			
3			
4			
5			

Do you need help to manage your mental health *

- ☐ Yes
☐ No

Substance abuse

Do you use drugs and alcohol? *

- ☐ Drugs & Alcohol
☐ Drugs
☐ Alcohol
☐ Neither

Do you have a drug or alcohol worker? *

- ☐ Yes
☐ No

Please give details such as Company, Support worker, Contact details, any prescription info *

Additional support and contact

Do you receive regular support from any of the following listed agencies? *

- ☐ Social Worker
☐ Probation Officer

- ☐ Psychiatrist/ Psychologist
☐ No

Financial Information

Benefit claims? *

- ☐ Universal Credit
☐ PIP
☐ ESA
☐ Pension

Universal credit value? *

£

How often is this received *

- ☐ Daily
☐ Weekly
☐ Monthly
☐ Other

How often is this received *

- ☐ Daily
☐ Weekly
☐ Monthly
☐ Other

PIP Value *

£

How often is this received *

- ☐ Daily
☐ Weekly
☐ Monthly
☐ Other

Pension Value *

£

How often is this received *

- ☐ Weekly
☐ Monthly
☐ Other

Do you have any Court Fines? *

- ☐ Yes
☐ No

Court fine Monthly value (If Known) *

£

Do you have any loans currently being deducted form your benefits? *

- ☐ Yes
☐ No

Monthly loan repayment value *

£

Are you currently repaying your outstanding loans or arrears? *

- ☐ Yes
☐ No

Do you have a bank account *

- ☐ Yes
☐ No

Would you like help in setting up a bank account? *

- ☐ Yes
☐ No

Do you have a bank card? *

- ☐ Yes
☐ No

Criminal Record

Have you ever been convicted or accused of Arson? *

- ☐ Yes

Have you ever been cautioned with, charged with or convicted of sex offences? *

- ☐ Yes
☐ No

Have you ever been convicted of a criminal offence or have you got any pending court appearances? *

- ☐ Yes
☐ No

Nature of offence(s) *

Are you subject to any orders? *

- ☐ DRR - Drug Rehabilitation Requirement
☐ Probation
☐ Injunctions
☐ No
☐ Other

Date orders end? *

Day

Month

Year

Do you have any restraining orders? *

- ☐ Yes
☐ No

Are you restricted/excluded from any of the following areas? *

- ☐ No
☐ Salford
☐ Preston
☐ Chorley
☐ South Ribble
☐ Oldham
☐ Wigan

☐ Other

Support Needs

Reasons for requiring supported housing Please tick all that apply. *

- ☐ Access to local services rough sleeping
- ☐ Improved quality life
- ☐ Skills to eat healthily
- ☐ Access voluntary services
- ☐ Ability to manage personal hygiene
- ☐ Increase social and community networks
- ☐ Unplanned hospital admissions
- ☐ Accessing drug alcohol services
- ☐ Getting involved in activities
- ☐ Gaining and / or maintaining employment/Education/training
- ☐ Deteriorating financial position
- ☐ Help to find other help
- ☐ Risk of offending
- ☐ Risk of self-harm
- ☐ Ongoing health issues
- ☐ Developing problem solving skills
- ☐ Developing personal competence
- ☐ Increased feelings of being more independent
- ☐ Ability to manage Money better
- ☐ Increased Knowledge
- ☐ Becoming Homeless / evicted (within 28 Days)
- ☐ Ability to manage ongoing health problems
- ☐ Access to health services
- ☐ Build an alternative support network
- ☐ Risk of domestic abuse
- ☐ Frequent presentation to accident and emergency
- ☐ Reduce social isolation
- ☐ Obtaining or maintaining a suitable home
- ☐ Increased feelings of being less reliant
- ☐ Risk of long term worklessness
- ☐ Developing household skills
- ☐ Feeling more involved
- ☐ Risk of harm to others
- ☐ Reducing feelings of isolation
- ☐ Ability to keep home safe and secure
- ☐ Ability to manage a healthy lifestyle
- ☐ Developing self-esteem

☐ Developing people skills

☐ Increased confidence.

☐ Other

Do you have contact with your family?

☐ Yes

☐ No

Name of Referrer Agency ***Agency Details ***

Name of Assessor

Telephone Number

Email Address

Referring Persons Mobile Number *

Please enter a valid phone number.

What is your connection to the area? *

- ☐ Born here
- ☐ Living in this area already
- ☐ Immediate family member lives here
- ☐ Fleeing domestic violence

Reasons for homelessness *

- ☐ Job loss/Unemployment
- ☐ Addiction
- ☐ Domestic abuse
- ☐ Mental illness
- ☐ Foreclosure
- ☐ Unsupported teen
- ☐ Difficulty escaping long-term homelessness
- ☐ Prison Leaver
- ☐ Leave to remain granted
- ☐ Other

Preferred area to live ***Country of Origin *****Please Specify Other Origin ***

First Language *

Please Select

Sexual Orientation *

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Homosexual
- ☐ Lesbian
- ☐ Transgender
- ☐ Prefer not to say
- ☐ Other

Do you have communication needs? *

- ☐ Yes
- ☐ No

Health care providers *

- ☐ Doctors
- ☐ Opticians
- ☐ Dentist
- ☐ Other

Declarations

Referrals can only be completed by a professional person or professional body who can qualify for the actual need of Exempt Supported Accommodation. I agree that the information contained in this referral form is true and accurate. I consent to it being used as part of the assessment and risk process. By signing below, I agree that all the information provided is true and I will inform the provider of any changes. I also understand that R4H have the right to refuse support if I have provided and information that is incorrect/false.

INFORMATION SHARING: I understand that R4H will carry out checks on the information I have provided through contact with other agencies', e.g., Medical Professionals, Probation Services, social services etc. I am signing to say I give permission to share information about me with other agencies

Client's Second name

Marital Status *

Please Select

Religion *

- ☐ No Religion/ Atheist
- ☐ Christian
- ☐ Muslim
- ☐ Sikh
- ☐ Buddhist
- ☐ Hindu
- ☐ Jewish
- ☐ Prefer not to say

Client Gender *

- ☐ Male
- ☐ Female
- ☐ Other

Are any of the following needed

- ☐ Large Print
- ☐ Braille
- ☐ Easy read
- ☐ Pictures and symbols
- ☐ Audio tape/CD
- ☐ BSL/Makaton
- ☐ Translator/ Interpreter
- ☐ Other

Do you need help to register with health care providers? *

- ☐ Yes
- ☐ No

Ethnic origin *

- ☐ White: British
- ☐ White: Irish
- ☐ White: Other
- ☐ Asian/Asian British: Indian
- ☐ Asian/ Asian British: Pakistani
- ☐ Asian/Asian British: Bangladeshi
- ☐ Asian/ Asian British: Other
- ☐ Black/ Black British: African
- ☐ Black/ Black British: Caribbean

- ☐ Black/ Black British: Other
- ☐ Chinese/ Chinese British
- ☐ Mixed: White & Asian
- ☐ Mixed: White & Black Caribbean
- ☐ Mixed: White & Black African
- ☐ Mixed: Other
- ☐ Prefer not to say

Physical and Mental Information

Client's first name

Do you have any physical health conditions? *

- ☐ Yes
- ☐ No

Are you registered with a GP *

- ☐ Yes
- ☐ No

Do you need reminding to take your medication? *

- ☐ Yes
- ☐ No