Copies of all completed referral forms and any queries must be forwarded to:

***Torfaen Floating Support (TFS),***
*Central Referral & Assessment Team,*
*Torfaen Voluntary Alliance, Portland Buildings,*
*Commercial Street, Pontypool,*
*Torfaen NP4 6JS*

Tel: (01495) 742461
e-mail: TESS@tvawales.org.uk/tfs@tvawales.org.uk

**Service User/Referrers – Please complete as much information as possible up to and including the signature boxes on Page 7. The rest of this form will be used to complete the Waiting List Assessment by a member of the Central Referral & Assessment Team. In the first instance this will be attempted via telephone contact.**

**Have you accessed this service before?** Yes ☐ No ☐

**Do you know which agency provided the support and when?**

| |
|---|
| |

## Initial Contact Assessment

**Service User Basic Details:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Title: | Mr ☐ | Mrs ☐ | Miss ☐ | Ms ☐ | Dr. ☐ | Other ☐ |
| Forenames: | | | | | | |
| Surname: | | | | | | |
| Previous Surname: | | | | | | |

| N.I Number | L | | L | | N | | N | | N | | N | | N | | N | | L | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

Sex M ☐ F ☐ Date of Birth

| D | D | M | M | Y | Y |
|---|---|---|---|---|---|
| | | | | | |

| |
|---|
| Address:<br><br>Post Code: |

| How long have you been living there? | Telephone: |
|---|---|
| Mobile: | E-Mail address: |
| Safe Contact Number: | Best time of day to be contacted: |

**What is your current Landlord Type (Please tick one)?**

| | |
|---|---|
| ☐ Local Authority Temporary | ☐ Bed & Breakfast |
| ☐ Hostel | Housing Associations (please tick one)<br>☐ Bron Afon<br>☐ Melin<br>☐ Charter<br>☐<br>☐ |
| ☐ Voluntary/Charitable Organisation | ☐ Private Rented |
| ☐ Owner Occupier | ☐ Other (please state) |

**Relationships**

Are you currently in a relationship/do you have a partner? YES / NO

What is your marital status:

**Partner's Details (if applicable):**

| | |
|---|---|
| Title | Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr. ☐ Other ☐ |
| Forenames | |
| Surname | |
| Previous Surname | |

N.I Number | L | | L | | N | | N | | N | | N | | N | | N | | L | |

Sex M ☐ F ☐ Date of Birth (D D M M Y Y) ☐☐☐☐☐☐

**Dependants and Others Who Live In Your Household**

| Full Name | Date of Birth | Relation-ship | Agencies/ professionals involved | Are they on the Child Protection Register? | Do you have parental responsibility? | Do they live with you? | If no, where are they accommodated? |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
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| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

**Emergency Contact**

Who would you like us to contact in case of emergency?

| | |
|---|---|
| Their name: | |
| Their address/place of contact | |
| Their telephone number: | |
| Their relationship to you: | |

**Ethnicity**

How would you describe yourself?

**White**

- ☐ British
- ☐ European
- ☐ Irish
- ☐ Welsh
- ☐ English
- ☐ Scottish

**Mixed**

- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean

**Other Groups**

- ☐ Arab
- ☐ Chinese
- ☐ Gypsy / Traveller
- ☐ Vietnamese
- ☐ Yemeni

**Asian or Asian British**

- ☐ British Born Asian
- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Sri Lank an

**Black or Black British**

- ☐ Black British
- ☐ African
- ☐ African Somali
- ☐ Caribbean

**Other (please state)**

How would you describe your sexual orientation?

- ☐ Heterosexual
- ☐ Bi-sexual
- ☐ Gay/lesbian
- ☐ Other (please specify)
- ☐ Prefer not to say

How would you describe your religious beliefs?

- ☐ Baha'i
- ☐ Buddhist
- ☐ Catholic
- ☐ Protestant
- ☐ Methodist
- ☐ Shinto
- ☐ Hindu
- ☐ Moslem
- ☐ Jain
- ☐ Sikh
- ☐ Jewish
- ☐ Prefer not to say
- ☐ Rastafarian
- ☐ Atheist
- ☐ Agnostic
- ☐ None
- ☐ Other (please specify)

What is your first language?

Fluent ☐ Read and write ☐ Read only ☐ Conversational ☐ Basic ☐

| Which languages do you speak? | |
|---|---|

Are you registered as disabled? Yes ☐ No ☐

**Asylum Seeker Status**

Are you an Asylum Seeker/Refugee? YES / NO / DON'T KNOW

*If 'NO', please go to next section.*

**Only answer this section if you have Asylum Seeker Status**

If 'YES', do you have a Home Office letter granting you permission to stay or NASS 35 card? YES / NO

Are you being supported by NASS? YES / NO

What is your NASS reference number: ☐

Are you in contact with the Welsh Refugee Council? YES / NO

If you have applied for asylum where was this? ☐

**Previous Accommodation**

Where was your last stable accommodation within the past two years?

| Address: | Dates (From – To) |
|---|---|
| Name of Agency/Landlord/Provider: | |

Reason for leaving this accommodation:

**(please tick one only)**

- ☐ Entered an Institution
- ☐ Period in This Institution Ceased
- ☐ Loss of Accommodation
- ☐ Positive Move
- ☐ Harassment/Victimisation
- ☐ Returned to Home Area
- ☐ Left the Area
- ☐ Other

Specify/describe:

If you are under 18 years of age, are you able to return home? YES / NO

If NO, please explain the circumstances:

Have you ever been evicted? YES / NO
If yes, why were you evicted, where and when was this?

Do you currently have any rent or mortgage arrears? YES / NO
If yes, how much rent/mortgage arrears is outstanding? £----------

Have you, or are you in the process of making an arrangement to clear them?
YES / NO

**Income**
What is your total weekly income? £ _ _ _ : _ _

Are you employed? Unemployed ☐ Employed ☐
*If employed proceed to next section*

**Benefits**
Which benefits are you in receipt of?

| Description | Amount | Description | Amount |
|---|---|---|---|
| Income Support | | Job Seekers Allowance | |
| Incapacity Benefit | | Disability Living Allowance | |
| Housing Benefit | | Council Tax Benefit | |
| Child Benefit | | Maternity Allowance | |
| Pension | | Pension Credit | |
| Child Tax Credit | | Working Tax Credit | |
| ESA | | Severe Disability Premium | |
| Carers Allowance | | Attendance Allowance | |
| Other | | | |

**Employment details** - *(information will be treated in confidence and not shared with employer)*

| Name of employer:<br>Address:<br><br>Post Code: | | |
|---|---|---|
| Tel: | Start date: | Finish date: |

**Literacy**

Do you have any difficulties reading and writing?

**Areas Needing Support** **(If any area of risk is identified the provider must contact TVA for any detail)**

**Housing Related Support Needs**

Please tick all the boxes that apply to you and/or a member of your household

| | | | |
|---|---|---|---|
| Domestic Abuse | | Homeless/Potentially Homeless | |
| Learning Difficulties | | Chronic Illness | |
| Mental Health | | Vulnerable Single Parent | |
| Alcohol Issues | | Vulnerable Two Parent Family | |
| Drug Issues | | Older Person | |
| Refugee | | Frail Elderly | |
| Physical Disability | | Sensory Impairment | |
| Young & Vulnerable | | HIV/AIDS | |
| Offending Issues | | Other | |
| From the above list, please tell us which is the most important to you ('Lead Need') | | | |

| Are you referring yourself to this service? Yes ☐ No ☐<br><br>If 'No', please give the contact details of the person making the referral, their relationship to you ***or*** job title, and the agency they work for (if applicable): |
|---|
| Name: |
| Relationship to Service User/Job Title: |
| Contact details, Address/Telephone number: |

| **Applicant's signature:**<br><br>**Print Name:** **Date:**<br><br>*NB: Please note that we are unable to process this application without your signature* |
|---|

**Service Users – Please note, the rest of this Form will be completed with you by a member of the Central Referral & Assessment Team via a Telephone Assessment, and you will be asked to give verbal consent in order to process your referral onto the TFS Waiting List, allowing us to share your information with a Support Provider, in order for support to commence.**

| **Referrer's signature:** (if applicable)<br><br>**Note to referrer:** this form must be counter-signed by the applicant wherever possible or you must state that verbal consent has been given for the referral to be made. Failure to do so may result in a delay in processing.<br><br>**Print Name:** **Date:** |
|---|

PLEASE ENSURE WHEN EMAILING YOU CLEARLY NOTE CONSENT HAS BEEN GAINED FROM THE SERVICE USER

**Referrers – Please note, The Central Referral & Assessment Team, will contact the Service User in order to complete the rest of the form. However, if you feel you have further information that would be beneficial to the Assessment, please add this if possible.**

## Promoting Personal and Community Safety

### 1. People are feeling safe

| Fire safety/home security/personal safety/alarms/Neighbourhood Watch<br>Outline of Issue |
|---|
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

### 2. Contributing to the safety and wellbeing of themselves and others

| Domestic abuse/harassment/parenting/drug and alcohol abuse/ASBO/legal and justice services<br>Outline of Issue |
|---|
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## Promoting Independence and Control

### 3. Managing accommodation

| Homelessness/affordable accommodation/transfers/resettlement/tenancy responsibilities/maintenance<br>Outline of Issue |
| --- |
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

### 4. Managing relationships

| Social integration/peer support/confidence building/advocacy/mediation/communication skills<br>Outline of Issue |
| --- |
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## 5. Feeling part of the community

| Accessing local facilities and services/activities/life skills/transport issues<br>Outline of Issue |
| --- |
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## Promoting Economic Progress and Financial Control

## 6. Managing money

| Benefits/debt management/budgeting/bill payments/maximising income<br>Outline of Issue |
| --- |
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## 7. Engaging in education/learning

| Identify education or skill needs/access to learning options/course costs/literacy and numeracy<br><u>Outline of Issue</u> |
|---|
| <u>Risk Associated Yes/No</u><br><u>If Yes- Brief Detail</u> |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## 8. Engaging in employment/voluntary work

| Access career, employment advice/develop C.V./job applications/volunteering/identify child care services<br><u>Outline of Issue</u> |
|---|
| <u>Risk Associated Yes/No</u><br><u>If Yes- Brief Detail</u> |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## Promoting Health and Wellbeing

### 9. Physical health

| Register with G.P. dentist, opticians/access primary & specialist health care/ adaptations & mobility aids<br>Outline of Issue |
| --- |
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

### 10. Mental health

| Access mental health services/access medication/engagement with services/access support groups<br>Outline of Issue |
| --- |
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

## 11. Healthy and active lifestyle

| Access appropriate services/healthy eating/fitness & leisure activities/mobility aids/home hygiene<br>Outline of Issue |
|---|
| Risk Associated Yes/No<br>If Yes- Brief Detail |
| What support are you currently receiving and from whom?<br><br>☐ None |
| Priority<br><br>General ☐<br>Critical ☐ |

**Community Care, Supervision and Statutory Agency Involvement**

Have you been in care in the last 10 years? YES / NO
(Children's home/foster care)

RISK - **(If any area of risk is identified the provider must contact TVA for any detail)**

Are you in the process of or have you been convicted of any criminal offences?
YES / NO

**Have you, during the past 12 months, been a victim of domestic abuse or felt threatened and controlled by your partner or family member?**

**(For Support and Advice, please ring Domestic Abuse All Wales helpline - 0808 80 10 800)**

| | Tick box below if applies | | Tick box below if applies |
|---|---|---|---|
| **YES** | | **NO** | |

Please Identify risk management requirements:

Female staff only YES/NO

Male staff only YES/NO

Two to one staff support delivery YES/NO

Has any risk been identified on the referral form? YES/NO

Is a joint visit necessary for the risk/needs assessment? YES/NO

Was the service user identified on the TCBC EWD? YES/NO
If yes, please state the Name/contact No for the EWD:

| |
|---|
| |

**Agencies currently providing support via TFS**

## *Other Agency Involvement*

Please give details of any involvement by the prospective service user, partner or dependants with any other agency and when they last had contact:

| Name of Service User with involvement | Organisational Details | Currently involved | Contact in last 6 months | Contact 6 months to 1 year ago | Contact over 1 year ago |
|---|---|---|---|---|---|
| Are you/your family currently registered with a *local* GP? YES / NO / DON'T KNOW | | | | | |
| | **Name of your G.P.**:<br>Practice Address:<br><br>Telephone Number: | | | | |
| | **Community Psychiatric Nurse**:<br>Address:<br><br>Telephone Number: | | | | |
| | **Social Worker**:<br>Address:<br><br>Telephone Number: | | | | |
| | **Support Worker**:<br>Address:<br><br>Contact person:<br>Telephone Number: | | | | |
| | **Probation Officer**:<br>Address:<br><br>Telephone Number: | | | | |
| | Name of Agency<br>Firm Name:<br>Address:<br><br>Contact person:<br>Telephone Number: | | | | |
| | Name of Agency<br>Address:<br><br>Contact person:<br>Telephone Number: | | | | |

# SERVICE USER'S AGREEMENT TO SHARE INFORMATION

**Name:** ……………………………………………………………………………………………………………………….………..

**Address:** ………………………………….……………………………………………………………………………………………….

……………………………………………………………………………..………… **Post Code:** …………………….……

**Part A (mandatory for service delivery)**
I hereby authorise the Support Service Provider and Torfaen Voluntary Alliance to disclose and share with each other any relevant information regarding my circumstances held in manual and/or computerised records.

I understand that this information will be used in order to assess the level of floating support services that I require, and also to monitor the effectiveness of the service that I receive. This may include the disclosure of information to Torfaen Supporting People Team and Welsh Assembly Government for scheme monitoring and review purposes.

**Part B (voluntary)**
I understand that the Support Provider or Torfaen Voluntary Alliance may use this information in discussions with other agencies as detailed below:

☐ Landlord/Mortgage Provider

☐ Health Services. GP, Health Visitor etc.

☐ Social Services

☐ Police/Probation/YOT

☐ Local Authority – TCBC

☐ Community Mental Health Team

☐ Housing Benefit

☐ Solicitor

☐ Court Services

☐ Creditors/loan company's/Bank etc.. (Specify) ………………………………….

☐ Drug/Alcohol Services (Specify) ………………………………….

☐ Education/Training provider

☐ Other ……………………………………………………………………………

☐ Other ……………………………………………………………………………

I understand that this information will be treated as CONFIDENTIAL and will not be disclosed to any other parties without my prior consent unless it is in respect of the support services that I require.

**The only exception to this will be if the Support Provider or Torfaen Voluntary Alliance believes that I pose a danger to myself or where my actions may put others at risk.**

Service User's Signature: ………………………………………………………………. Date: ……/……/………

(This referral/assessment was completed via the telephone and the Service User has given verbal consent for the information to be shared with the Support Provider.) ☐

Signature of Witness:………………………………………………………………… Date: ……./…./……….

Print Name: ……………………………………………….. Designation: ……………………………………….

To be completed by Referral Assessment Officer at point of Verification with Service User