

Please fill in all details with as much information as possible and send by email to referrals@pfshousing.co.uk.

If referring from Justice.gov.uk, email pfshreferrals@pfsh.cjsm.net.

For Salford & Tameside: we cannot accept referrals directly – please complete a Duty To Refer at the local authority, who will then refer individuals to us.

SECTION 1

About the Applicant

Personal details and current circumstances of the person being referred.

HAS THE APPLICANT GIVEN THEIR CONSENT FOR THIS REFERRAL?

Yes No

FULL NAME

ARE THEY KNOWN BY ANY OTHER NAME?

CONTACT NUMBER

EMAIL ADDRESS

DATE OF BIRTH

NATIONAL INSURANCE NO.

GENDER

Male Female Prefers not to say

NEXT OF KIN

NATIONALITY

PREFERRED LANGUAGE

DO THEY HAVE DEPENDENT CHILDREN?

Yes No

IF YES, HOW MANY CHILDREN?

ARE THEY PREGNANT?

Yes No

DUE DATE (IF APPLICABLE)

CURRENT / LAST ADDRESS

TYPE OF ACCOMMODATION

Private Rented Council / Housing Association Family / Friends Hostel Temporary Accommodation Other

LANDLORD'S CONTACT DETAILS

REASON FOR LOSING ACCOMMODATION

PREVIOUS ADDRESS HISTORY – PAST 5 YEARS

ADDRESS	FROM	TO	ACCOMMODATION TYPE	REASON FOR LEAVING

DO THEY OWE RENT ARREARS AT ANY ADDRESS?

Yes No

IF YES, HOW MUCH IS OWED?

ANY PAYMENT PLAN IN PLACE?

Yes No

REASON FOR REFERRAL

SECTION 1 CONTINUED

Referral Area & Housing Register

WHAT AREA ARE THEY BEING REFERRED TO?

LOCAL CONNECTION TO THAT AREA?

 Yes No

IF NO LOCAL CONNECTION, WHICH AREA DO THEY HAVE A LOCAL CONNECTION WITH?

APPLIED TO JOIN THE HOUSING REGISTER?

 Yes No

IF NO, EXCLUDED FROM HOUSING REGISTER?

 Yes No

RIGHT TO RENT CHECK?

 Yes No

ADDITIONAL INFORMATION

SECTION 2

Financial Information

Please tick which benefits the applicant receives and state the amount and frequency.

BENEFIT	AMOUNT £	FREQUENCY	BENEFIT	AMOUNT £	FREQUENCY
<input type="checkbox"/> Income Support			<input type="checkbox"/> Retirement Pension		
<input type="checkbox"/> Job Seekers Allowance			<input type="checkbox"/> Incapacity Benefit		
<input type="checkbox"/> Child Benefit			<input type="checkbox"/> Personal Independence Payments (PIP)		
<input type="checkbox"/> Other Income			<input type="checkbox"/> Universal Credit		

CURRENTLY IN PAID EMPLOYMENT?

 Yes No

IF YES, WORKING HOURS

 Full-time (30+ hours) Part-time (<30 hours)

CURRENTLY IN EDUCATION?

 Yes No

IF YES

 Full-time Education Part-time Education

ASSESSED AS HAVING LIMITED CAPABILITY FOR WORK (LCW) OR WORK-RELATED ACTIVITY (LCWRA)?

 N/A No LCW LCWRA

SECTION 3

Applicant's Support Needs

Medical, GP, and current support organisations.

REGISTERED WITH A GP?

 Yes No

GP CONTACT NUMBER

GP NAME & ADDRESS

ANY MEDICAL CONDITIONS, DISABILITIES OR REGISTERED DISABLED?

 Yes No

IF YES, PLEASE GIVE DETAILS

ANY BLOOD-BORNE INFECTIONS?

 Yes No

IF YES, PLEASE GIVE DETAILS

ANY ACCESSIBILITY REQUIREMENTS FOR FACE-TO-FACE ASSESSMENT?

 Yes No

IF YES, PLEASE GIVE DETAILS

SECTION 3 CONTINUED

Current Support Organisations

Is the applicant currently receiving support from any of the following?

ORGANISATION	NAME OF SERVICE AND/OR SUPPORT WORKER	CONTACT NUMBER
Probation		
Social Worker		
Alcohol Services		
Floating Support		
Drug Services		
Mental Health		
Counselling		
Women's Aid		
Health Visitor		
Other		

IF CURRENTLY IN SUPPORTED ACCOMMODATION, WHY DO THEY NEED TO MOVE TO ALTERNATIVE ACCOMMODATION?

E.g. was the support insufficient, or do they need to move for another reason?

Type & Level of Support Required

Please indicate the type of support needed and at what level.

TYPE OF SUPPORT	HIGH	MEDIUM	LOW	N/A
Housing / Homelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tenancy Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vulnerable Older Person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Misuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family in Need (incl. child protection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaving Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Risk of Re-offending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Complex Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FURTHER INFORMATION

SECTION 4

Risk Assessment

Please complete all fields carefully. Provide details where indicated.

RISK FACTOR	YES / NO	DETAILS
History of arson	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Issues with males	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Issues with females	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Challenging behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Racist views	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of violence — to staff members	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of violence — to other service users	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of violence — to the public	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of violence — to family or friends	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of sexual assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Aggressive behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of anti-social behaviour (ASB)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
At risk of abuse / exploitation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of self-harm	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Suicidal thoughts & feelings	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental health issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Substance misuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Danger to children	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Registered sex offender	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Offender currently under MAPPA	<input type="checkbox"/> Yes <input type="checkbox"/> No	

MORE INFORMATION ON RISKS

SECTION 5

Convictions & Cautions

Please provide details of any convictions or cautions below. You do not need to include convictions considered as spent under the Rehabilitation of Offenders Act 1974.

REASON FOR CONVICTION	DATE OF CONVICTION	SENTENCE RECEIVED

SECTION 6

Referrer's Details

I have asked for the applicant's **explicit consent** to share the information contained within this form with other agencies for them to assess their needs and suitability for support and/or supported accommodation for the purposes of homelessness.

NAME OF PERSON COMPLETING REFERRAL

ORGANISATION

JOB TITLE

CONTACT NUMBER

EMAIL ADDRESS

REFERRER SIGNATURE

DATE OF REFERRAL

SECTION 7

Client Declaration

I confirm that the information provided in this referral form is accurate and complete to the best of my knowledge. I understand that this information may be used to assess my support needs and determine appropriate services or accommodations. If information is found to be false, this may impact our decision. I give consent for this information to be shared with relevant support agencies and professionals involved in supporting me, where necessary and appropriate.

CLIENT SIGNATURE

DATE

SECTION 8

Additional Information

Please use the space below to provide any further details that may help us understand the client's circumstances, risks, support needs, or anything else relevant that hasn't been captured elsewhere in this form: