Service Referral Application Form

This form is for referrals for the following services:

- Support in your own home
- Care in your own home
- St Anne's housing with support
- Shared Lives
- Residential Care
- Nursing Care

Additional Information

- This form can be filled in by the applicant and/or referrer/helper.
- Please answer all questions as truthfully and as fully as you can.
- We will ask other people about you to confirm what you say.
- We will deal with this application as quickly as we can.
- If you need any help filling it in, please ask someone else or we can help you.

Return Instructions

Please return both **Referral Application Form** and **Risk Assessment Form** together, otherwise your application will be incomplete.

If returning the forms electronically, please return to: referrals@st-annes.org.uk

If returning by post:
St. Anne's Community Services
Head Office
Unit 5, Fountain Court, 12 Bruntcliffe Way, Morley
Leeds
LS27 0JG

All the information given in this form will be treated confidentially. A copy of St Anne's Confidentiality Policy is available on request.

If you would like a form translated into another language, please let us know.

CONTACT US IF YOU NEED A LARGE PRINT VERSION OF THIS FORM

1. Personal Details

Family name:

First name:

Date of Birth: Age: Marital status:

2. Present address

Address:

Post Code:

Tel/ Mobile No:

Please tick what kind of property this is

Hospital Ward	( )	Nursing Care Home	( )
Residential Care Home	( )	Homeless Hostel	( )
Probation Hostel	( )	Other Hostel	( )
Shared or Group Home	( )	Family Home	( )
Own Home	( )	Other	( )

Other - please specify: _____

Contact address (If different from above)

3. Referring person – details

Name:

Agency:

Address:

Post Code:

Tel No/ Mobile number:

4. Other agencies

Please tell us about other people and organisations who offer you a support or care service, e.g. Care Manager, Social Worker, Psychiatrist, CPN, GP, Home Care, Day Centre Key Worker, etc.

Name:
Agency:
Address:
Post Code:
Tel: **Mobile:**

Name:
Agency:
Address:
Post Code:
Tel: **Mobile:**

Name:
Agency:
Address:
Post Code:
Tel: **Mobile:**

Name:
Agency:
Address:
Post Code:
Tel: **Mobile:**

5. Paying for your Housing Support / Care

How will you pay your rent or support/care costs?
Welfare Benefits ( ) Wages ( ) Other Income ( )
Please specify:

6. Housing

Do you want Housing as well as Support?
Yes ( ) No ( )

If you have ticked No move on to part **7** of this section.

Please tick the type/s of Housing you are looking for.

Care Home
Nursing ( )
Residential ( )

Via Community Carers Scheme ( )
Other ( )
Please Specify _____

Supported Housing
24 Hour Staffed Shared Housing ( )
High Support Shared Housing ( )
Low Support Shared Housing ( )
Low Support Flat or Bed-Sit ( )

Please tell us where you would like to live

	City	Areas Preferred	Areas Considered
1.			
2.			
3.			

7. Support

Please tick the reason/s you need Support.

Learning Disability ( )
Mental Ill-Health ( )
Alcohol or Substance Use ( )
Physical Disability ( )
Homelessness ( )
Other ( )
Please specify _____

Roughly how much support do you think you need?

Number of days a week ( )
Number of hours a day ( )

Tell us more about why you need support:

8. Personal Care

Do you need help with personal care? Yes ( ) No ( )

If yes, please tell us more about the care you need:

9. Support/ Care Assessments

Have you recently been assessed for your support/care needs by another agency or professional e.g. Care Manager, Social Worker, Psychiatric Nurse, Occupational Therapist, etc

Yes ( ) No ( ) Don't know ( )

If yes, please give the name and details of the person who assessed you.

Name:
Agency:
Address:
Post Code:
Tel: **Mobile:**

Are you under Section 117 of the Mental Health Act?

Yes ( ) No ( ) Don't know ( )

10. Keeping Informed

The application process to St Anne's services involves a number of stages. Do you want us to let someone else besides you know what is happening? This could be a friend, relative or professional worker.

Please give us the details of who this is.

Name:
Agency:
Address:
Post Code:
Tel: **Mobile:**

11. Equal Opportunity Policy

No application will be refused on the grounds of sexuality, gender, religion, ethnicity or disability. To help us make sure this happens please answer the following questions.

Gender: Female ( ) Male ( )

Do you consider yourself disabled? Yes ( ) No ( )
If you don't want to answer this question please tick here ( )

How would you describe your disability?_____

How would you describe your ethnicity? Please tick one of the boxes below which best fits this description.

White	British		Irish		Other			
Mixed (White And)	Black Caribbean		Black African		Asian		Other	
Black or Black British	Caribbean		African		Other			
Asian or Asian British	Indian		Pakistani		Bangladeshi		Other	
Chinese or Other Ethnic Group	Chinese		Other					

If you don't want to answer this question please tick here ( )

The law does not allow us to 'grant benefits' to Staff, Board Members or their relatives. Are you an Employee or Board Member of St Anne's Community Services, or a relative of either?

Yes ( ) **No ( )**

12. Signature

As far as I know the information, I have given on this form is true. I understand that providing false information may result in St Anne's seeking repossession of my property or stopping my support or care.

Signature: _____ Date: _____

13. Access to Information

I understand that in order to continue with this application, St Anne's may need to ask for information from other agencies which have worked with me. By signing below, I give permission for St Anne's to ask for this information and for other agencies to provide it.

Signature: _____ Date: _____

Please note this form must be submitted along with the Risk Assessment Form

A LIFE WITHOUT LIMITS FOR THE PEOPLE WE SUPPORT