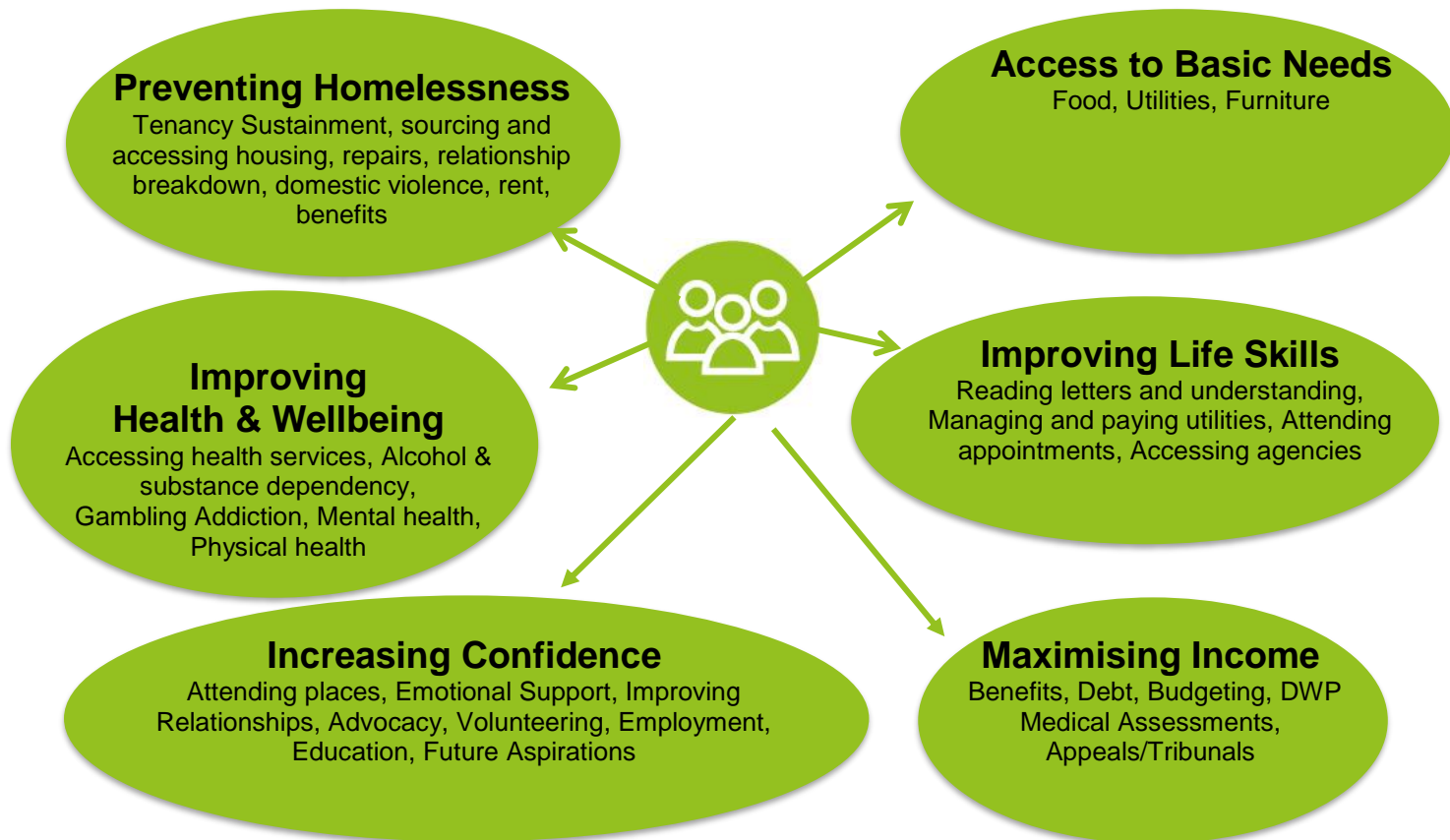


Application Form for Community Support

Please complete this form if you require support in any of the following areas;



Please give us as much information as you can

This form can be returned by:

POST to: CARE, 18 Hainton Avenue, Grimsby, DN32 9BB

or EMAIL to: support@carenelincs.co.uk

If you need help making an application please phone us on 01472 232310. Alternatively, you can call in person to our office at the above address Monday to Friday between 10:00am-3:30pm

TERMS OF USE

- CARE aims to empower and enable people to do things for themselves, supporting them with their journey to achieve independent living.
- Support Workers will visit people in their own home or within a community setting.
- The service is free to service users.
- Support can last for up to 1 year and will be reviewed together every 6 months.
- The amount of weekly support given will be led by the needs of the person receiving support set in the context of the named support workers caseload.

1. APPLICANT DETAILS			
Title:	First Name:	Last Name:	
Previous Name:			
Address:		Email:	
Post Code:			
Home Tel:	Work Tel:	Mobile:	
Date of Birth:		National Ins No:	

! If you are completing this application on behalf of someone please complete this section. However, if you are completing this form for yourself please proceed to section 3. !

2(a) DECLARATION	
Does the applicant know this referral is being made?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have they agreed to it?	Yes <input type="checkbox"/> No <input type="checkbox"/>
I consent to the information provided on this form being passed to CARE Community Support who will assess my priority and need for a Community Support Service. I understand that all information given will be treated as confidential and I give my permission to seek or share any necessary information from or with other relevant agencies and organisations. This may include sensitive personal information.	
Signature of referrer:	Date:
NB We are unable to accept referrals without the individuals consent. Please try to get this form signed by the applicant whenever possible but, as long as you have got their verbal agreement, we will respond initially as if they have signed it.	
Applicant's signature:	Date:

2(b). REFERRAL AGENCY			
Organisation:			
Referrer's Name & Job Title:			
Address:			
Postcode:			
Tel:		E-mail:	

3. COMMUNICATION REQUIREMENTSDo you have any special communication requirements? Yes No

Please give details of requirements (e.g. language, Braille, reading difficulties):

4. ECONOMIC STATUS Full time employed (24 hours or more per week) Part time employed (less than 24 hours per week) Govt. Training Job Seeker Retired Not seeking work Full Time Student Long/short term sick Other**5. HOUSEHOLD DETAILS:**

Who else lives with the applicant?

Name	Date of Birth	Gender (M/F)	Relationship to Applicant

Total number of people in the household:

Is anyone in the household expecting a baby? Yes No Expected due dateAre there any pets? If yes, please detail. Yes No **6a. TYPE OF ACCOMMODATION:**

- | | |
|---|--|
| <input type="checkbox"/> Private tenant
<input type="checkbox"/> Owner occupier
<input type="checkbox"/> Housing Association/Registered Social Provider
<input type="checkbox"/> With family/friends
<input type="checkbox"/> Temporary Accommodation | <input type="checkbox"/> Supported housing
<input type="checkbox"/> Women's refuge
<input type="checkbox"/> Mobile home/caravan
<input type="checkbox"/> No fixed abode
<input type="checkbox"/> Other (please give details) |
|---|--|

6b. Have you ever been homeless? Yes No

6c. If yes, why?

7. IS THE APPLICANT IN CONTACT WITH ANY OTHER ORGANISATIONS / AGENCIES? Y/N			
Agency	Reason	Contact name	Telephone number & Email

8. NEED FOR COMMUNITY SUPPORT

Please tick () all those that are relevant

Our support aims to help you to: -	
Preventing Homeless: - Tenancy Sustainment Sourcing and Accessing Housing Repairs Relationship Breakdown Domestic Violence Rent Benefits	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Increasing Confidence: - Attending Places Emotional Support Improving Relationships Advocacy Volunteering Employment Education Future Aspirations	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Improving Health and Wellbeing: - Accessing health services Alcohol dependency Substance dependency Gambling Addiction Mental Health Physical Health	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Improving Life Skills: - Reading Letters and understanding Managing and paying utilities Attending Appointments Accessing agencies	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Maximising Income Benefits Debt Budgeting Medical Assessments Appeals/Tribunals	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Access to basic needs: - Food Utilities Furniture	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Please provide full information as to why you require Community Support:

9. RISK INDICATORS

Our team work in clients' homes; usually in a lone working capacity. Therefore it is imperative that you detail all known/potential risks below.

Please do not leave this section blank as we are unable to process the referral without this information.

If we are able to offer a floating support service, we will carry out a full support needs and risk assessment. This information will be used to assess how your needs can be met most appropriately, as well as ensuring the safety of our workers.

Please indicate if there is current or past history of any risk(s) in any of the following areas for anyone in the home:

Violence	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Verbal abuse / aggression	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Carrying / use of weapons	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Arson / criminal damage	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Reports of sexually inappropriate behaviour	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Mental health problems	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Self-harm or suicide attempts / thoughts	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Use alcohol to excess	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Use non prescribed drugs / solvents	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Medication non compliance	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Does the community where you live pose a risk?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Do you have friends & associates who present a danger?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
Does your home have physical hazards or poor ease of exit?	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>

If known, please provide full information below of any risks and their management. This may include past actions or events. Please include details of known convictions.

10. How did you hear about CARE?

11. Data Protection Notice

- CARE will use your personal information (as provided by you in this application form and any additional information which you may give us for this purpose in the future), in connection with your application.
- By signing this form you consent to CARE processing your special categories of personal information, and discussing with other service providers where necessary for the purposes of progressing your application.
- You have a right to ask for a copy of your information that we hold on you and to correct any inaccuracies in your information.

Full details of our privacy notice can be obtained by visiting our website www.carenelincs.co.uk/privacy-notice.htm

12. DECLARATION

For the purpose of processing my Community Support application, I consent to the use of my name, date of birth and other relevant data as set out above. I understand that this information will not be used for any other purpose without my consent unless authorised by law.

Applicant's signature:

Date:

For office use only

DATE REFERRAL RECEIVED:

DATE REFERRAL PROCESSED:

FOR TELEPHONE REFERRALS:

TAKEN BY (CARE TEAM MEMBER – PLEASE SIGN & PRINT NAME)

Equal Opportunities Monitoring Form

We keep records of people who apply to us for support. This is to ensure that our service is provided on an equal basis without discrimination on the grounds of age, gender, race, ethnicity, sexuality, disability or religion. Any information you choose to give us will be treated in confidence and will be used for monitoring purposes only.

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GENDER:		Male <input type="checkbox"/>				Female <input type="checkbox"/>			Other <input type="checkbox"/>	
AGE:		under18 <input type="checkbox"/>	18-24 <input type="checkbox"/>	25-29 <input type="checkbox"/>	30-34 <input type="checkbox"/>	35-39 <input type="checkbox"/>	40-49 <input type="checkbox"/>	50-59 <input type="checkbox"/>	60-69 <input type="checkbox"/>	70+ <input type="checkbox"/>
RACE:		ETHNICITY:								
White <input type="checkbox"/>		British <input type="checkbox"/>		Irish <input type="checkbox"/>		Any other White background <input type="checkbox"/>				
Black <input type="checkbox"/>		African <input type="checkbox"/>		Caribbean <input type="checkbox"/>		Any other Black background <input type="checkbox"/>				
Asian <input type="checkbox"/>		Bangladeshi <input type="checkbox"/>		Indian <input type="checkbox"/>		Pakistani <input type="checkbox"/>		Arab <input type="checkbox"/>		
		Chinese <input type="checkbox"/>				Any other Asian background <input type="checkbox"/>				
Mixed <input type="checkbox"/>		White & Asian <input type="checkbox"/>		White & Black African <input type="checkbox"/>		White & Black Caribbean <input type="checkbox"/>		Any other Mixed background <input type="checkbox"/>		
Other <input type="checkbox"/>		Gypsy <input type="checkbox"/>		Romany <input type="checkbox"/>		Traveller <input type="checkbox"/>		Prefer not to say <input type="checkbox"/>		
SEXUAL ORIENTATION:										
Bisexual <input type="checkbox"/>		Gay <input type="checkbox"/>		Heterosexual <input type="checkbox"/>		Lesbian <input type="checkbox"/>		Prefer not to say <input type="checkbox"/>		
DISABILITY:										
If yes, please tick relevant box below:		Yes <input type="checkbox"/>		No <input type="checkbox"/>				Don't know <input type="checkbox"/>		
Mobility <input type="checkbox"/>		Visual Impairment <input type="checkbox"/>		Hearing Impairment <input type="checkbox"/>				Mental Health condition <input type="checkbox"/>		
Autistic Spectrum Condition <input type="checkbox"/>		Learning disability <input type="checkbox"/>		Progressive Disability/Chronic Illness <input type="checkbox"/>				Other -		
RELIGION:										
Buddhist <input type="checkbox"/>		Hindu <input type="checkbox"/>		Sikh <input type="checkbox"/>				Muslim <input type="checkbox"/>		
Jewish <input type="checkbox"/>		Christian <input type="checkbox"/>		Prefer not to say <input type="checkbox"/>		Not known <input type="checkbox"/>		None <input type="checkbox"/>	Other -	
MARITAL STATUS:										
Single <input type="checkbox"/>	Married <input type="checkbox"/>	Separated <input type="checkbox"/>		Divorced <input type="checkbox"/>		Living with Partner <input type="checkbox"/>		Other -		

Thank you for taking the time to provide this information.