

FLOATING SUPPORT REFERRAL FORM (INITIAL ASSESSMENT)

1. APPLICANT DETAILS

Surname _____

Forenames _____

Date of Birth _____

National Insurance Number _____

Gender : Male Female Transgender

Marital Status: Single Married Co-habiting
 Separated Divorced Widowed

Current / Previous Address _____

Telephone Number _____

2. DEPENDANTS / FAMILY CIRCUMSTANCES

(Please give details of family, children, others)

3. EMERGENCY CONTACT

Name _____

Relationship _____

Contact Address _____

Contact Telephone Number _____

4. HOUSING HISTORY

ADDRESS	TYPE – i.e. Private, NIHE, Hostel	DATE FROM	DATE TO	REASON FOR LEAVING
1				
2				
3				
4				
5				

Have you applied for NIHE Accommodation? YES NO

Number of points _____

How long have you been on the waiting list for? _____

Have you any arrears outstanding from previous tenancies? YES NO
Please give details _____

5. HEALTH FACTORS

GP (Name) _____ Practice _____ Tel No: _____

(Please give details of medication, illness or other health factors)

6. ARE THERE ANY ISSUES OF MENTAL/EMOTIONAL HEALTH?

YES

NO

If yes please give details _____

7. HAVE YOU A DISABILITY?

YES

NO

If yes please give details _____

8. HAVE YOU ANY CULTURAL/LANGUAGE ISSUES?

YES NO

If yes please give details _____

9. SOURCE OF INCOME DETAILS

Are you employed at present? YES NO

Have you been previously employed? YES NO

If yes please give details _____

Are you currently in receipt of benefits? YES NO

If yes please give details _____

10. STATUTORY/VOLUNTARY SUPPORT

Do you receive statutory support or support from other voluntary agencies?

YES

NO

Community Mental Health Team

Probation Board

Social Services

Day Centre

Addiction Treatment Unit

Housing Executive

Health Visitor

Other

If yes please give details(Name of Contact, Frequency of Contact etc)

11. OFFENDING INFORMATION

	YES	NO
DO HAVE ANY PREVIOUS CONVICTIONS?		
EARLIEST DATE OF RELEASE/PAROLE (IF APPLICABLE)		
HAVE YOU EVER BEEN CONVICTED OF :		
OFFENCES AGAINST CHILDREN OR YOUNG PERSONS UNDER THE AGE OF 17 ?		
OTHER OFFENCES OF A SEXUAL NATURE ?		
OFFENCES OF VIOLENCE ?		

If 'yes' please give details _____

12. OUTLINE OF CLIENT NEEDS

Referral Agency :- Please give details of client's background and any specific areas where you feel support is required. _____

13. ISSUES CONTRIBUTING TO CURRENT SITUATION

Applicant :- Please give details of areas where you feel you need support.

- | | | | |
|-----------------|--------------------------|-----------------------------------|--------------------------|
| Drinking Issues | <input type="checkbox"/> | Saying 'NO' | <input type="checkbox"/> |
| Gambling | <input type="checkbox"/> | Use of my time | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | Use of my money | <input type="checkbox"/> |
| Loneliness | <input type="checkbox"/> | Getting a job | <input type="checkbox"/> |
| My temper | <input type="checkbox"/> | Keeping a job | <input type="checkbox"/> |
| My family | <input type="checkbox"/> | Coping on my own | <input type="checkbox"/> |
| My friends | <input type="checkbox"/> | Getting on with other people | <input type="checkbox"/> |
| Reading&Writing | <input type="checkbox"/> | Getting into trouble with the law | <input type="checkbox"/> |

Additional Information to above: _____
