

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

What type of Shared Lives service is being requested? (please select)

- A long term Shared Lives service
- A short break service
- Home from hospital (if this box is ticked please fill in the relevant information on page 2)
- Day time services
- Just Next Door (semi-independent living)
- Other

Last name		Title	
Forenames (s)		Likes to be known as	
Current Address		Gender	
		Date of birth	
Telephone		Nat Insurance no	
		NHS no	
Next of Kin/carer		Social/Care worker	
Name		Name	
Relationship		Team	
Address		Address	
Telephone		Telephone	
Email		Email	
GP name or Medical Centre contact details (if known)			
Who is the main correspondent for the purposes of this referral?			

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Please tick any boxes that describe the person's current situation:

- Is a young person in transition from foster care
 - Is currently living at home with parents/family
 - Is currently in a residential school or college
 - Is currently living alone
 - Is currently living in a residential care home
 - Is currently in a short stay/respite setting
 - Is currently living in a supported living tenancy
 - Is currently assessed under a section of the Mental Health Act (section 2,3 or 117)
 - Health/Home from Hospital
 - Other (please describe below)
-

Please tick the statement that relates to the PRIORITY NEEDS for the person who wants the service – this is to identify the MAIN support need, other needs can be identified below:

- | | |
|--|--|
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Is a person over age 60 |
| <input type="checkbox"/> Mental health issues | <input type="checkbox"/> Physical disabilities |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Sight impairment/is non sighted |
| <input type="checkbox"/> Hearing impairment/deaf | <input type="checkbox"/> Acquired brain injury |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Reablement from hospital |

If this is a Home from Hospital referral please complete the section below.

If not continue to page 3.

Name of hospital			
Name of ward		Phone number	
Other professionals involved	Professionals contact details		
Intermediate Care Team/Discharge team contact details			
Estimated date of discharge		Is this person medically fit for discharge?	
Is there a discharge plan in place:			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
Please enclose with the referral			

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Please describe the ethnic origin of the person requesting the service				
Asian or Asian British	Black or Black British	Mixed	White	Other ethnic group
<input type="checkbox"/> Indian	<input type="checkbox"/> Caribbean	<input type="checkbox"/> White and Black Caribbean	<input type="checkbox"/> British	<input type="checkbox"/> Chinese
<input type="checkbox"/> Pakistani	<input type="checkbox"/> African	<input type="checkbox"/> White and Black African	<input type="checkbox"/> Irish	<input type="checkbox"/> Any other ethnic group
<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Any other black background	<input type="checkbox"/> White and Asian	<input type="checkbox"/> Any other White background	
<input type="checkbox"/> Any other Asian background		<input type="checkbox"/> Any other mixed background		

FURTHER INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Where does the person wish to live (for long term service requests) Please specify any geographical areas that would be considered/ would definitely not be considered.

For Short breaks/Home from Hospital: what areas would the person consider travelling to for a Short break/Home from Hospital (including Devon, Torbay, Cornwall, Plymouth and Somerset)

How often would the person like short breaks? e.g one weekend a month.

Ideally what type of household would the person prefer to be in?

- | | |
|---|---|
| <input type="checkbox"/> Prefer to be the only person being supported | <input type="checkbox"/> Prefer company of similar age |
| <input type="checkbox"/> Would like a household with animals/pets | <input type="checkbox"/> Do not like cats Do not like dogs |
| <input type="checkbox"/> Prefer a quiet household | <input type="checkbox"/> Prefer an active household |
| <input type="checkbox"/> No particular preferences | |

Does the person wanting the service have the mental capacity to understand and make a decision about where they live?

- Yes
 No

If not, has a best interest decision meeting been held?

- Yes
 No

Please supply any written evidence.

Does the person being supported or the appropriate representative understand how Shared Lives works?

- Yes
 No

If no, can we make contact with them?

- Yes
 No

Are there any complex family issues/relationships/safeguard issues?

- Yes
 No

If yes, please supply details.

FURTHER INFORMATION ABOUT THE PERSON CONTINUED

**Tell us about the person wanting the service.
e.g. hobbies and interests, weekly routine, family and friends.
The more you can tell us, the more it will help us to find a match within our service.
*Please enclose a recent needs assessment/care plan.***

**What are the main areas of support that the person requires from the service?
e.g. help with personal care, daily living skills, emotional support**

FURTHER INFORMATION ABOUT THE PERSON CONTINUED

Does the person have any specific support needs we should take into account in matching?

e.g. use of stairs, wheelchair user, mobility aids, specific communication needs, night time needs.

Please list.

Are there any areas of risk to the person or to others around them?

Please provide any risk assessments.

Can the person be left alone for any period of time?

Is the person currently taking any medication? Do they have any known allergies?

Please specify.

Any specific dietary requirements? Is a special diet required? Are there any choking risks and are the speech and language team involved?

FURTHER INFORMATION ABOUT THE PERSON CONTINUED

Any specific health issues which will need support? (example- skin integrity concerns)

Are there any continence needs?

Other services used by the person (long term placements only)

Does the person attend any day time /leisure activities that need to be maintained?

- Yes**
- No**
- Don't know**

If yes, please give details.

Any other information about the person requesting the service?

FUNDING

Who is likely to have funding responsibility for this service?

- Local authority commissioned service
- Direct Payment/ held by who? Please specify below.
- Self-funded by person/other
- Health Authority

Is any funding already agreed in principle to meet this service request?

- Yes
 - No
- If yes, please give details

The cost of the service will be determined based on the support needs of the individual.

Is the person currently funded under section 117 of the Mental Health Act

- Yes
- No
- Not known

Is the person currently making any contribution to the cost of any of their care?

- Yes
- No

If yes, how much and on what frequency?

THE PERSON'S FINANCIAL SITUATION

Does anyone act as? (tick box)			
<input type="checkbox"/> Appointee			
<input type="checkbox"/> Corporate Appointee			
<input type="checkbox"/> Deputy			
<input type="checkbox"/> LPA			
Details of anyone appointed to manage the person's financial/personal affairs on their behalf			
Name		Relationship	
Address		Telephone	
		email	
Does the person requiring the service have access to their own bank account?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
Does the person requiring the service have a mobility funded vehicle?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
Does a financial capacity assessment need to be completed?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
<i>If yes, please submit the assessment.</i>			
Does the person have any paid or voluntary employment?			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
<input type="checkbox"/> Don't know			
<i>If yes, please give details</i>			
.....			
Does the person attend college/educational activity			
<input type="checkbox"/> Yes			
<input type="checkbox"/> No			
<input type="checkbox"/> Don't know			

THE PERSON'S FINANCIAL SITUATION

We can not progress the referral without some financial information, so please complete *as fully as possible*.

FOR LONG TERM SERVICES ONLY: Does the person have any capital that you are aware of?			
<input type="checkbox"/> Not known <input type="checkbox"/> Under £16,000 <input type="checkbox"/> Between £16,000 and £20,000 <input type="checkbox"/> Over £20,000 <input type="checkbox"/> Over £23,500 <input type="checkbox"/> Trust fund			
FOR LONG TERM SERVICES ONLY Please list the service user's current benefits and sources of income and provide proof .	Amount £	How often	Any further information
Universal Credit			
Does that include household costs?	Yes No		
Employment Support Allowance			
Income Support			
Severe Disablement Allowance			
Personal Independence Payment	Daily Living	<input type="checkbox"/> <input type="checkbox"/>	
	Mobility		
Disability Living Allowance	Care		
	Mobility		
Pension Credit			
State Retirement pension			
Pension- Occupational			
Other Income			
Earnings from paid employment			

The person completing the form needs to sign here:

Signature.....
 Date.....
 Print Name,
 Relationship to person.....

It is important that the person requesting the service from Shared Lives South West is aware that the information on this form will be shared with staff and some Shared Lives carers from Shared Lives South West in order to find the best match possible in our service. Please make sure this has been discussed and is understood by the person as appropriate.

Signature of person requesting service (where applicable)

.....

Attachments – the more information you can send us, the easy it is for us to find a match.

Please tick any further information/documentation that is attached

- Current or very recent needs assessment
- Current or very recent care plan or person centred plan
- Current or very recent risk assessment
- Other additional information.
- MCA/FCA assessments
- Hospital discharge plan
- Benefit Information

Please specify.....

RETURNS

Please send your referral form and any additional information by email to:

Devon: enquiries@sharedlivessw.org.uk

Cornwall: cornwall@sharedlivessw.org.uk

Somerset: somerset@sharedlivessw.org.uk

Referrals from Devon County Council, Torbay Council & Plymouth Council or self funders in the county send to:

Referrals, Shared Lives South West, Suite 3, Zealley House, Greenhill Way, Kingsteignton, Newton Abbot, TQ12 3SB. **Tel:** 01626 360170

Referrals from Cornwall Council or self funders in the county send to:

Referrals, Shared Lives South West, Trewellard Farm, Wheal Rose, Scorrier, Redruth, TR16 5DH. **Tel:** 01209 891888

Referrals from Somerset Council or self funders in the county send to:

Referrals, Shared Lives South West, The Wagon House, Eaglewood Business Park, Ilminster TA19 9DQ. **Tel:** 01460 477980