***Lettings Appendix 1: HAIL Application Form for Regional Specialist Visiting Housing Support Service***



**Regional Specialist Visiting Housing Support Service**

**(Mental Health)**

Thank you for your interest in referring to the HAIL Regional Visiting Support Service. To ensure that we can process your application promptly please ensure that the following items are completed before returning the referral to HAIL.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **YES** | **NO** |
| **1** | Did you contact the HAIL office to discuss this case and ensure we have capacity? |  |  |
| **2** | Have you completed ALL parts of the referral form? (Incomplete referral forms will not be considered) |  |  |
| **3** | Has the client consented to this referral? |  |  |
| **4** | Have you advised your client that this service is a short term service? |  |  |
| **5** | Does your client have a tenancy? |  |  |
| **6** | Is this tenancy at risk? |  |  |
| **7** | Does your client have a mental health diagnosis? |  |  |

In order to facilitate a successful outcome for our shared client, it is important that we maintain contact and keep one another informed of developments. We would therefore be grateful if you could support us by:

* Ensuring that we are invited to ALL client review meetings.
* Informing us immediately of any new risks arising regarding their tenancy.
* Informing us immediately of any changes or alterations regarding their mental health treatment or care.

**If you have answered NO to any of the 7 questions above, please discuss this with one of the HAIL team (on 01- 6718444 ) prior to submitting the referral.**

**Our address is Second Floor, Central Hotel Chambers, 7-9 Dame Court, Dublin 2 DO2 X452**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

N.B This application form is to be completed by professionals from approved referral agencies.

**Part 1: Applicant Details**

|  |  |  |
| --- | --- | --- |
|   | **Applicant 1** | **Partner/Joint Applicant (where applicable)** |
| Name of Applicant |  |  |
| Current Address |  |  |
| Date of birth | DD / MM / YYYY | DD / MM / YYYY |
| Phone Number |  |  |
| Gender |  |  |
| Nationality |  |  |

**Are you**: Single  Married  Divorced/Separated Widowed 

Cohabiting

**Other Members of Household** (who will be moving with you)

|  |  |  |
| --- | --- | --- |
| NAME | Relationship to you | DATE OF BIRTH |
|  |  | DD / MM / YYYY |
|  |  | DD / MM / YYYY |
|  |  | DD / MM / YYYY |
|  |  | DD / MM / YYYY |
|  |  | DD / MM / YYYY |

Housing History (most recent first):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Address: | From: | To: | Type Of Accommodation | Reason For Leaving: |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**What type of accommodation do you live in at present?** *(Please tick one) –*

Local Authority Housing.. Group home…. Homeless Hostel……

HSE Hostel .… Private rented… Hospital……

 Women’s Refuge…….. Family/Friends.. Other…………

|  |
| --- |
|  |

**If you are in the process of being offered accommodation, what kind is it?**

**Local Authority Housing  Housing Association  RAS **

**Private Rented  Own home  Family Friends **

**Is the current tenancy at risk?** Yes  No 

**If so please identify the reason:**

Rental increase  Arrears  Anti Social Behaviour 

Relationship Breakdown  Unfit Accommodation  Harassment 

Other 

|  |
| --- |
| Please specify other …. |

***If not already housed by a Local Authority or Housing Association,* are you registered for Housing with a Local Authority? Yes No**

**Which Local Authority are you registered with?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which type of Housing List are you on?** Homeless… Housing…

**Please give your registration Number and time on list** : Reg No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Time on list: Years \_\_\_\_\_\_\_\_ Months:\_\_\_\_\_\_\_\_

**Part 2: Referring & Other Agency info**

**Name of Agency**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Staff making the referral:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Job Title:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ­­­

**Contact address of Agency**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone numbers:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Mobile number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your email address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long have you known the applicant**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you committed to offering on -going support to the applicant if accepted to the Regional Service?**

 Yes… No…

**Consultant Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consultant Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consultant Contact Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of referring Local Authority / HSE area:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please List the details of people below where applicable:**

|  |  |
| --- | --- |
| **GP:** Name AddressPhone No.  | **Community Mental Health Nurse** Name  Address: Phone No. |
| **Social Worker:** Name Address Phone No. | **Next of Kin:** Name  Contact DetailsPhone No.  |

**Please list other statutory and other agencies that are currently working with the applicant e.g, Other Community & Voluntary Groups/Agency, Counselling service etc:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Agency | Name of Contact Worker | Contact Worker Job Title | Address | Phone Number |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**Part 3: Support and Housing Needs Assessment**

**HAIL support services are only offered to persons with a primary need regarding Mental Health,** however all needs are assessed in order to agree a holistic support plan and as such it is important that the table below is completed giving as much information as possible:

**Support Needs (please be aware that level of need does not affect acceptance)**

|  |
| --- |
|  N**eed** |
| Frequent Support  | OccasionalSupport | No Support/ Independent |
| **Alcohol /Drug Dependence/ Misuse** |  |  |  |
| **Chronic Illness/Mobility& Access/Personal Care** |  |  |  |
| **Compulsions/Managing Behaviour/Self Harm** |  |  |  |
| **Cooking/Using Domestic Equipment/ Housekeeping** |  |  |  |
| **Cultural, Religious, Diversity** e.g. Language  |  |  |  |
| **Domestic Abuse** |  |  |  |
| **Education and Employment** |  |  |  |
| **Finance** e.g. Budgeting, bills, Applying for Benefits |  |  |  |
| **Exploitation/ Harassment** |  |  |  |
| **Health & Safety/Life Skills** e.g. phone/transport |  |  |  |
| **Learning Disability/ Literacy Issues** |  |  |  |
| **Medication**  e.g. Management and monitoring of |  |  |  |
| **Mental Health** e.g. Awareness of, management of |  |  |  |
| **Offending/at risk of offending** (incl arson history) |  |  |  |
| **Parenting/Children** incl. Child protection Issues |  |  |  |
| **Sensory impairment** e.g. blind/deaf |  |  |  |
| **Other** (please state) |  |  |  |

Where a critical high or medium support need has been identified above please give details of current support services and risk management approaches in place:

|  |
| --- |
|  |

**Please state the Applicants Current Mental Health Diagnosis:**

|  |
| --- |
|  |

**Brief Psychiatric History: (Please attach Medical Case Summary & Risk Profile where appropriate)**

|  |
| --- |
| *Please include Indicators of relapse, triggers, onset behavior etc*  |

**Current Mental State:**

|  |
| --- |
|  |

**Current Medication:**

|  |
| --- |
|  |

**Is the applicant self medicating**? Yes  No 

**In Receipt of IM Depot?** Yes  No 

**Physical Illness or Learning Disabilities:**

|  |
| --- |
|  |

**Relationships**

**Does the applicant receive support from others in the community such as family etc….**

|  |
| --- |
| **Please detail………** |

**Please give details of Applicants Social, educational, training & employment Supports that are currently in place:**

e.g. National Learning Network, walking groups, clubs etc

|  |
| --- |
|  |

**Part 4 Risk Screen:**

**Please submit Medical / Social Work Report where there is any identified risk.**

*(Note level of risk does not affect acceptance)*

**Does the applicant have any history of physical / verbal aggression?**

|  |
| --- |
| *\*Please provide detail, triggers & dates:* |

**Has the applicant a history of attempted suicide, self harm or expressing suicidal ideation?**

|  |
| --- |
|  |

**Does the applicant have any history of risky impulsive behaviour?**

|  |
| --- |
|  |

**Please note: HAIL Mental Health Tenancy Sustainment Workers are lone working in the client’s home and community. Is there any risk, to the best of your knowledge, that the client may present under lone working conditions?**

Yes **** No ****

**Details of lone working risk:**

|  |
| --- |
|  |

**Are there any child protection issues present with the applicant?**

 Yes  No 

**Is there a current risk assessment management plan in place for the applicant?**

 Yes  No 

**If so will it be supplied, with the agreement of the applicant?**

 Yes  No 

**Please give other relevant information including any known risks not mentioned above:**

|  |
| --- |
|  |

**Regional Service**

**Consent to share and process confidential information about you**

To support you in relation to your mental health and well-being, housing needs and social integration, your HAIL Mental Health Tenancy Support Worker will need you to share some of your personal information. This includes sensitive personal information (known as your personal data).

We need your consent to:

* work with you and other agencies (as named below) sharing only relevant and appropriate information to ensure your support needs are met
* process your personal data for example: your name, date of birth, address, mental health team details or GP, diagnosis

We will only share your personal data with these agencies and people on a ‘need to know’ basis. This means where these agencies and people have a specific and genuine need for information in relation to your housing or mental health.

(please only tick where you agree) :

* local authorities □
* your social worker □
* landlords □
* Department of Social Welfare □
* your solicitor □
* your doctor and relevant mental health professionals □
* self identified supports such as your family or friends. □

We will keep your personal data for no more than 1 year after your last contact with our Regional Mental Health Visiting Support Service.

At your first meeting you will be provided with a copy of our Data Protection Statement. This tells you more about your data protection rights and what we must do to protect your personal data. Please read the statement and sign the consent form.

**Consent form**

I give my consent to HAIL to:

* process my personal data
* share my personal data with the agencies and people listed above; and
* work with these agencies to support me.

**Exclusions:**

I do not want HAIL to communicate with the following:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |
| --- |
| My name (in block capitals): |
| My signature:  |
| Date: Day Month Year |

I give consent to be contacted by HAIL Peer Support Volunteers about social events

Yes □

No □