

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

- A long term Shared Lives service
- Day time services
- A short break service
- Just Next Door (semi-independent living)

INFORMATION ABOUT THE PERSON WHO WANTS THE SERVICE

Last name:		Title:	
Forenames (s):		Likes to be known	
Current Address:		Gender:	
		Date of birth:	
Telephone:		Nat Insurance 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?			

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)
- 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 the person over the age of 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 | |

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		

INFORMATION ABOUT THE PERSON'S FINANCIAL SITUATION

We cannot progress a referral without some financial information, so please complete this section as fully as possible

Who is likely to have funding responsibility for this service?

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

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

Yes
 No
 Not known

FOR LONG TERM SERVICES ONLY: Does the person have any capital that you are aware of?

Not known
 Under £16,000
 Between £16,000 and £20,000
 Over £20,000
 Over £23,500
 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		
	Mobility		
Disability Living Allowance	Care		
	Mobility		
Pension Credit			
State Retirement Pension			
Pensions- Occupational			
Other Income			
Earnings from paid employment			

Does the person have any paid or voluntary employment?
 Yes No Don't know

If yes, please give details

Does the person attend college/educational activity
 Yes No Don't know

Is any funding already agreed in principle to meet this service request?
 Yes No Don't Know

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 making any contribution to the cost of any of their care?
 Yes No

If yes, how much and on what frequency?

Has a financial capacity assessment been undertaken? Please give details and attach evidence.

Details of anyone appointed to manage the person's financial/personal affairs on their behalf

Name:		Relationship:
Address:		Telephone:
		email:

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: what areas would the person consider travelling to for a short break (including Devon, Torbay, Cornwall and Plymouth)

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/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 no, has a best interest decision meeting been held?

Yes No

Please supply any written evidence.

**Tell us about the person wanting the service – what are their hobbies and interests, what do they do during the day and at the weekends?
Any information about their family and other key people in their life and so on. 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 where available.**

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)

**Does the person have any mobility issues we should take into account when matching?
(in-cluding use of stairs, wheelchair use, mobility aids used and so on)**

Are there any areas of risk that we should be aware of? (for the person and/or to others supporting them)

Is the person currently taking any medication? Please specify.

Any specific dietary requirements?

Any specific health issues which will need support?

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?

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 in our Shared Lives service.

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

Please specify Please send your referral form and any additional information by email to: enquiries@sharedlivesw.org.uk or by post:

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
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
01209 891888

For further details about how we will use our personal information, please read our privacy policy: <http://sharedlivesw.org.uk/cookies-privacy-accessibility/>