TENANCY SUPPORT SERVICE – REFERRAL FORM

NAME OF REFERRER ___________________________ **CONTACT NO** __________________

NAME OF ORGANISATION______________________ **MOBILE NO** ____________________

DATE OF REFERRAL ___________________________ **FAX NO** _______________________

NAME:	**DATE OF BIRTH:**
ADDRESS:	
TEL NO:	
TENANCY START DATE:	

CONTACT DETAILS - How we can best contact the person (e.g. by phone, by joint visit, by letter)

OTHER HOUSEHOLD MEMBERS

Name	Gender	D.O.B	Relationship (e.g. partner, son etc)

ANY INDENTIFIED RISK TO STAFF OR THE PERSON YOU ARE REFERRING

CLIENT GROUP WHICH BEST DESCRIBES THE PERSON REFERRED

OLDER PEOPLE WITH SUPPORT NEEDS	
OLDER PEOPLE WITH MENTAL HEALTH	
FRAIL ELDERLY	
MENTAL HEALTH PROBLEMS	
LEARNING DISABILITIES	
PHYSICAL OR SENSORY DISABILITY	
SINGLE HOMELESS WITH SUPPORT NEEDS	
ALCOHOL PROBLEMS	
DRUG PROBLEMS	
OFFENDERS OR AT RISK OF OFFENDING	
MENTALLY DISORDERED OFFENDERS	
YOUNG PEOPLE AT RISK	
YOUNG PEOPLE LEAVING CARE	
WOMEN AT RISK OF DOMESTIC VIOLENCE	
PEOPLE WITH HIV/AIDS	
HOMELESS FAMILIES WITH SUPPORT NEEDS	
REFUGEES	
TEENAGE PARENTS	
ROUGH SLEEPER	
TRAVELLER	
SURVIVORS OF DOMESTIC VIOLENCE	
CARE-LEAVERS	
‘LOW LEVEL’ EX-OFFENDERS	
FIRST TENANCY	
YOUNG, PREGNANT MOTHER	

PLEASE INDICATE THE TYPE OF SUPPORT NEEDED BY TICKING ALL OF THE APPROPRIATE BOXES BELOW

TYPE OF SUPPORT NEEDED			
PERSONAL SAFETY & SECURITY ADVICE		CLAIMING BENEFITS	
REBUILDING RELATIONSHIPS/ ESTABLISHING SOCIAL CONTACTS		DEALING WITH DEBTS	
CONTACTING OTHER AGENCIES		ACCESSING TRAINING OR EMPLOYMENT	
HELP FINDING MORE SUITABLE ACCOMMODATION		BUDGETING	
OTHER (please specify)		ESTABLISHING NEW TENANCY	

CASE BACKGROUND

ARE ANY OTHER AGENCIES/PEOPLE INVOLVED (e.g. Social Services, Probation, Relative, Friend etc)

AGENCY	CONTACT DETAILS

Please return this form to:

Tenancy Support Service
Ashfield Home Limited
Broadway
Sutton-in-Ashfield
Notts
NG17 1AL

Tel: 01623 608888
Fax: 01623 608889
Email: ahlmail@ashfieldhomes.co.uk