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Auckland Home Solutions CIC

SUPPORTED HOUSING APPLICATION FORM

Please return the completed application form to:

Room 4,
Prince Bishops Court,
60 Kingsway,
Bishop Auckland,
County Durham,
DL14 7JF

Section 1 – General Information

Scheme applied for _____
2nd choice (optional) _____

Service User's Details

Applicants Name: _____

Date of Birth: _____

Present Address: _____

Postcode: _____

Telephone No: _____

Preferred Language: _____

Referral Details

Name of Referrer: _____

Job Title: _____

Organisation: _____

Address: _____

Postcode: _____

Telephone No: _____

E-mail address: _____

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Section 2 – Monitoring Information

Auckland Home Solutions CIC has a policy of providing equal access to its housing to all groups of people in society. We do not discriminate in respect of race, colour, gender, sexuality, disability, marital status, dependants, political view or creed.

In order that we can process your housing application, we ask you to provide us with the following information about yourself / client. Please complete the questions below in full. The information will not affect the application in any way.

Auckland Home Solutions CIC is required by the Tenants Services Authority to collect information on its lettings. Some of the questions in this section are used to collect this information and will not affect your application.

Who is completing this section? The Applicant The Applicant's Representative.....

The Applicant's Information			
What is your age (in years)			
Do you consider yourself to be	<input type="checkbox"/> Not disabled	<input type="checkbox"/> Unregistered disabled	<input type="checkbox"/> Registered disabled
Do you use a wheelchair	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you consider yourself to be ... (Please tick only one)			
White	<input type="checkbox"/> British	<input type="checkbox"/> Irish	<input type="checkbox"/> Other
Mixed	<input type="checkbox"/> White & Black Caribbean <input type="checkbox"/> White & Asian	<input type="checkbox"/> White & Black African <input type="checkbox"/> Other	
Asian or Asian British	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Bangladeshi
Black or Black British	<input type="checkbox"/> Caribbean	<input type="checkbox"/> African	<input type="checkbox"/> Other
Chinese or other ethnic group	<input type="checkbox"/> Chinese	<input type="checkbox"/> Other	
I prefer not to answer this question	<input type="checkbox"/>		

What type of accommodation do you currently / did you live in?

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What is the main reason for needing to be housed in the scheme you are applying for?

Client Group / Needs

Client Group / Needs	Main	Secondary		Main	Secondary
Physical Disability	Tick one <input type="checkbox"/>	Tick one <input type="checkbox"/>	Refugee/asylum seeker	Tick one <input type="checkbox"/>	Tick one <input type="checkbox"/>
AIDS / HIV	<input type="checkbox"/>	<input type="checkbox"/>	Young person at risk/leaving care	<input type="checkbox"/>	<input type="checkbox"/>
Degenerative and debilitating illness	<input type="checkbox"/>	<input type="checkbox"/>	Vulnerable woman with children	<input type="checkbox"/>	<input type="checkbox"/>
Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	Woman at risk of domestic violence	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health related problems	<input type="checkbox"/>	<input type="checkbox"/>	Frail older person	<input type="checkbox"/>	<input type="checkbox"/>
Drug related problems	<input type="checkbox"/>	<input type="checkbox"/>	Singe homeless In need of support	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol related problems	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Leaving penal establishment / probation referral	<input type="checkbox"/>	<input type="checkbox"/>			

Please provide details to any of the above you have ticked:

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Section 4 – Referral Information

TO BE COMPLETED BY THE REFERRER

What is your relationship to the Applicant? _____

How long have you known the Applicant? _____

Does the Applicant agree to this referral being made? Yes No

What are the reasons for the referral? (Please continue on a separate sheet if necessary)

What are the applicant's present support needs? (Tick all that apply)

Learning Disabilities	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	Institutionalisation	<input type="checkbox"/>
Mental Health	<input type="checkbox"/>	Life Skills (General)	<input type="checkbox"/>	Life Skills (Budgeting)	<input type="checkbox"/>
Physical Disabilities	<input type="checkbox"/>	Offending (Sex)	<input type="checkbox"/>	Offending (Other)	<input type="checkbox"/>
Substance misuse (Alcohol)	<input type="checkbox"/>	Refugee	<input type="checkbox"/>	Substance misuse (Drugs)	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	Challenging Behaviour	<input type="checkbox"/>	Frail older person	<input type="checkbox"/>
Degenerative Illness	<input type="checkbox"/>	AIDS / HIV	<input type="checkbox"/>	Racial harassment	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	Other			

Which of the above does the Applicant need most support with?

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Section 5 – Special Support Needs

Does the Applicant have any history of violent or challenging behaviour? Yes No

(i.e. Behaviour that may cause or risk injury to the Applicant or others)

If yes, please detail any incidents below:

Who may we contact for more details about this?

Name _____ Telephone _____

Does the applicant have any needs or preferences relating to their ethnicity, social / cultural or religious needs? Yes No

If yes, please give details below:



Section 6 – Physical Health

Please give history of any significant health problems:

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Section 7 – Mental Health

Does the Applicant have a history of mental health problems? Yes No

If yes, please provide details (e.g. diagnosis)

Is the Applicant on Care Programme Approach (CPA)? Yes No

If Yes Standard or Enhanced

Please provide a current CPA and Risk Assessment

Please detail professional contacts below:

	Name	Work Base	Frequency of Contact
Social Worker			
CPN			
Probation Officer			
Psychiatrist			
Consultant			
Health Visitor			
District Nurse			
Physiotherapist			
Other			

Do you consent to us contacting the above agencies in your care for more information, if required? Yes No

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Section 8 – Offending

Does the Applicant have a history of offending behaviour?

Yes No

If yes, please provide details


Is the Applicant on any Sex Offenders Register?

Yes No

If yes, please provide details



Is the Applicant subject to a Probation Order / Bail Condition / Supervision?


Yes No

Please provide detail and duration below:

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Section 9 – Signatures

Applicants Signature _____ Date _____

Referrers Signature _____ Date _____

