Sandwell
Metropolitan Borough Council

Floating Support

Referral form guidance notes.

Sandwell's Floating Support Service provide help and support to vulnerable adults in Sandwell who are finding it difficult to stay safe and healthy. They may be at risk of homelessness or finding it difficult to stay out of hospital or they may be at risk of harm.

Tasks we may undertake:

- Budgeting advice and assistance
- Liaise with other Council services
- Refer to services and charities
- Register with GP
- Read/explain correspondence
- Resettlement support
- Set up bills and accounts
- Advice around obtaining correct banding
- Safeguarding concerns
- Facilitate Hospital discharge
- Identify community activities/groups
- Liaise with debt agencies/bailiffs
- Charity applications
- Refer to Welfare Rights to check entitlement
- Assist with bank accounts
- Referrals for care assessments
- Referrals to mental health services
- Work alongside Healthy Homes scheme
- Assistance with DHP/LWP applications

Tasks we do not carry out:

- Taxi people to appointments etc
- We do not offer care/respite
- Undertake cleaning
- Do not handle/administer medication
- Move furniture
- Gardening
- We cannot obtain properties
- We cannot award priority for housing
- DIY/Furniture assembly
- Handle cash/cards
- Offer emergency accommodation
- Emergency food parcels (Unless as part of a wider package of support.)
- Gas and electricity money/vouchers (Unless as part of a wider package of support.)
- We are not a mental health service

If you need further clarification, please contact our Duty officer on 0121 569 7474 (Option 4) or email us at
Floating_support@sandwell.gov.uk

We are not an emergency service.
Please note we do not accept referrals where the **sole** need is; but may as part of a package of support

- Reading letters
- Completing a housing application
- Emergency food/gas/electricity etc
- Transport to Hospital appointments
- Check benefit entitlement

Having read this guidance, if you feel you still need support, please refer to our website at **www.sandwell.gov.uk** or call our customer services on **0121 569 7474 (Option 4).**

SANDWELL FLOATING SUPPORT SERVICE REFERRAL FORM

Privacy Notice

To understand more about why we collect your information, what we do with your information, how you can access your information, your personal information rights, how and to whom to raise a complaint about your information, please visit our privacy notice page at

http://www.sandwell.gov.uk/privacynotices

Are you eligible for the service - please tick all that apply.

☐	You must be either resident in Sandwell or placed out of borough in temporary accommodation by the Housing Solutions service or Sandwell MBC.
☐	You must have recourse to public funds.
☐	You should be aged 18 or over (there is no upper age limit).
☐	Young people aged between 16 and 17 will be considered who have been granted an independent tenancy or home and need support to sustain their accommodation.

Please tick yes or no to the statement that applies to you;
if you do not answer these questions we may not be able to accept your referral.

Criteria	**Yes**	**No**
1. I need support due to homelessness or at being at risk of homelessness	☐	☐
2. I am at significant risk of harm (for example safeguarding, domestic abuse, harassment due to vulnerability, race or culture)	☐	☐
3. I need support to prevent the risk of admission to hospital or require support following hospital discharge.	☐	☐

If none of the above statements apply to you then we will not be able to consider you for the Floating Support Service.

If you have answered **YES** to any of the above statements, please continue to tell us a bit more about your situation.

Please tick to indicate which particular area is making you feel vulnerable at the moment: It is essential you provide as much information as possible.	
Mental health	
Physical health	
Learning disability	
Substance misuse	
Homeless	
Leaving care	
Domestic abuse	
Family with children who are at risk of higher intervention (Children's services involvement/ youth offending)	

REFERRAL

Please ensure **ALL** sections of this form are completed to prevent any delay in the processing of your referral.

REFERRAL DETAILS			
Client name			
Client Date of Birth			
Client Address			
Client Telephone number			
Client NHS Number			
Client Ethnicity			
1st Language:		Interpreter needed	Y/N

Referral Date	

Capacity: Do you have capacity to make informed decisions about your own well-being?
Tick as appropriate: Yes ☐ No ☐ Don't know ☐

Do you want us to liaise with anyone else on your behalf if we need to arrange an assessment?
Tick as appropriate: Yes ☐ No ☐ Don't know ☐
If yes, please provide the person's contact name and telephone number below:

Are there any risks to the applicant or any other agency that we should be made aware of?
Tick as appropriate: Yes ☐ No ☐ Don't know ☐
If yes, please tell us more below:

Do you currently receive support from any of the following services?
Please provide details including any safeguarding concerns:

GP / Doctor:
Social Worker – Adult Services:
Social Worker – Children's Services:
Mental Health Services / CPA:
Probation / Youth Offending Team:
Drug / Alcohol Services:
Landlord / Warden:
Carer:
Hospital:
Other:

Have you ever had a criminal conviction?	**Yes**	☐	**No** ☐

Please tell us what outcome you want to achieve to maintain your own well-being, what do you expect from the service:

Please give us further information regarding your current circumstances and need for support:

Authority to Act on Behalf of and request information:

Finally, please confirm that you authorise the Floating Support Service to contact and request information and to act on your behalf with agencies and authorities as necessary

Signed _____ Date _____

In addition to the above, please complete below if you have completed this referral on behalf of the client:

Name _____

Contact Number _____

Relationship _____

Profession _____

When complete please return to Floating_Support@sandwell.gov.uk

Phone: 0121 569 7474 (Option 4)

Office use only:	**Date referral received:**
Delete as appropriate: Accepted / Rejected for assessment If rejected: Date letter sent informing client of decision not to offer service:	
Referral accepted, date allocated to assessor and assessors name:	
Client ID Number:	