

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- 670 32 65) prior to submitting the referral. Our address is 2nd Floor, Central Hotel Chambers, 7-9 Dame Court, Dublin 2

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 Address Phone No.	Community Mental Health Nurse Name Address: Phone No.
Social Worker: Name Address Phone No.	Next of Kin: Name Contact Details Phone 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**)

Need	Frequent Support	Occasional Support	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?

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:



Housing Association for Integrated Living

Regional Specialist Visiting Housing Support Service

(Mental Health)

I have read the entire application form and confirm that the information in it is correct. I give my consent for the following:

1. HAIL Housing Association to approach the referring agency and any individuals or agencies mentioned in this referral form for further details regarding my application and ongoing support in the future. This additional information assists HAIL in providing a more rounded picture of your support needs now and in the future.
2. HAIL Housing Association to store information related to my support on their secure Client Related Management System (CRM). This secure storing of information enables HAIL's services to provide a more comprehensive level of tenancy and housing support.

**Please note that under Data Protection Acts 1988 and 2003 you can request a copy of any information kept on computer about you. You can review on screen or get a print out of the information recorded about you on HAIL Housing Associations CRM, this can be done by applying in writing to the Head of Services. HAIL Support Staff will be available if requested to view this information with the person applying.*

Signed:

Witnessed:

Date:
