Pathways Universal Assessment & Referral Form (PUARF)

Please save the PUARF with the naming convention CLIENTINITIALS_DDMMMYY
(E.G JB_01APR2016)

Please complete this form for all referrals for the Lewisham supported housing pathways. **The onus for ensuring that the correct supporting documentation is attached to this form is with the referrer;** failure to attach or provide the correct documentation may result in delays processing the application / a rejection of the application.

PUARF's OLDER THAN 3 MONTHS WILL NOT BE ACCEPTED			
PUARF completed by:			
Staff Name:		Date Completed:	
Service Name		Contact No:	
Email:			

Mental Health:		Vulnerable Adult:		Young Person:	

Clients Full Name:			
Current Address:			
Mobile No:			
Email Address:			
NI No:			
HB Reference No:			
Gender:		DOB & Age:	
Nationality:		Ethnic Origin:	
First Language/ Interpreter Needed?:		If yes (specify language):	
Religion:		Sexuality:	
Is client pregnant?		Expected Delivery Date	
Is the client in NSNO Hub?		CHAIN No:	
Has the client slept rough in the past?			
Does the client have a pet? (e.g. dog)			
Next of kin details (mandatory for Young Persons Pathway):			
Name:		Relationship:	
Address:		Tel No:	

Last settled accommodation prior to homelessness *(only complete at first assessment)*					
Council Property/RSL:		Private Rented:		With Partner:	
Parental/Family Home:		In Care:		Other:	
(If other please specify):					

1. **Reason for referral –** Can be completed by the applicant or the referring agent (if you are the referring agent please state how long you have worked with the individual and in what capacity)

- Please explain the reason for referral to supported housing pathway
- Please include the reasons you why you feel that supported housing would be beneficial for you at this time.

2. **Clients Statement:**

- *What you hope to gain by living in supported accommodation?*
- *What type of accommodation do you feel you need?*

3. Current Accommodation:

Approved Premises:		Temporary Accommodation:		Hostel:	
NSNO Hub (No 2nd Night Out)		Rough Sleeping:		Friends/Family:	
Detox Unit:		Rehab Unit:		Residential Care:	
Prison		Assessment Centre:		Supported Housing (24 hr)	
Supported Housing (Semi Independent):		Supported Housing (Visiting/Floating):		Hospital:	
Other		*If **other** or **hospital** please give details:*			

4. Housing History

Please provide details of the clients housing history over the last 5 years. This information should also include details of any time spent in hospital, prison or periods of rough sleeping.

Reasons for leaving **MUST** be given. (Reasons could include: antisocial behaviour, abandonment, escaping violence, hospital admission, inability to cope, noise nuisance, mobility issues, period in custody, relationship breakdown, rent arrears)

Address *(include accommodation type)*	From	To	Reason for leaving

5. Support

Primary Support Need (please only check **ONE** box)					
Asylum Seeking		Care Leaver		Ex or current Offender	
Learning Disability		Mental Health		Older Person	
Physical Health		Rough sleeping		Sex working	
Alcohol Misuse		Substance Misuse		Young Person	
Dual Diagnosis (Please Specify)					
Fleeing Violence (Please Specify)					
Additional Notes: (If the receiving project needs to be aware of perpetrators of violence please include details)					

Secondary Support Need (tick as many as appropriate)					
Alcohol Dependency		Care Leaver		Drug Dependency	
Offending		Financial Problems		Older Person	
Learning Disability		Young Person		Mental Health	
Social Isolation		Physical Health		Refugee	
Relationship breakdown		Rough sleeping		Sex working	
Dual Diagnosis (Please Specify)					
Fleeing Violence (Please Specify)					
Additional Notes:					

6. Substance Use					
Alcohol User		Drug User		Poly User (Both)	

Is the client abstinent? (Over 3 days)	Yes		No	

(How long the client has been abstinent and/or if they have had periods of abstinence in the past. Also give details of how abstinence could be verified – i.e. if client had regular testing or self - reported)

Are there any triggers that can result in relapse?

Main Substance:				Age first used	
Street illicit		Prescribed by GP		Prescribed Substance Misuse Service	
Prescribed & illicit		Purchased legally		Other prescribed	
Frequency of use:			Weekly Spend		

Route of Administration									
Inject		Sniff		Smoke		Oral		Other (specify)	

Second Substance:				Age first used	
Street illicit		Prescribed by GP		Prescribed Substance Misuse Service	
Prescribed & illicit		Purchased legally		Other prescribed	
Frequency of use:			Weekly Spend		

Route of Administration									
Inject		Sniff		Smoke		Oral		Other (specify)	

Third Substance:				Age first used	
Street illicit		Prescribed by GP		Prescribed Substance Misuse Service	
Prescribed & illicit		Purchased legally		Other prescribed	
Frequency of use:			Weekly Spend		

Route of Administration									
Inject		Sniff		Smoke		Oral		Other (specify)	

ALCOHOL USE						
Alcohol Dependant?	Yes		No		Age first used	
Details of Alcohol: Type and units:						
Frequency of use:				Weekly Spend		
Additional Information:						

Is the client currently accessing support/treatment?	Yes		No	
If YES please give details including what support they are receiving and how long they have been accessing support/services and also include any contacts within the "support services involved in the clients current support" section):				
How does the client behave when under the influence?				
Are there any risks associated with their substance misuse? *(e.g. ASB/overdose/chaotic using practices)*	Yes		No	
(If YES please provide details and add to risk section):				

7. Mental Health				
Mental Health Diagnosis:				
Confirmed by a MH Professional?	Yes		No	
Client linked to CMHT?	Yes		No	
Additional information regarding support needs and services. (If you check a box please provide details in the additional notes section)				

Anger management		Anxiety		Bipolar	
Care Programme Approach (CPA)		Delusional Thoughts		Depression	

First Episode Psychosis		Forensic Mental Health		Home Secretary Restriction Order	
In Hospital		On Depot		Oral Medication	
Panic/Anxiety Attacks		Paranoia		Personality Disorder	
Schizophrenia		Self-Harm		Social Phobia	
Suicide Attempts		Suicidal Ideation		Receiving outpatient treatment	

Additional Notes

Is the client engaging with mental health services?	Yes		No	
(If YES please provide details)				

Has the client previously been linked to a mental health service?	Yes		No	
(If YES please provide details including dates):				

Has the client ever been sectioned?	Yes		No	
(If YES please provide details including date):				

Is the client taking medication or engaging in treatment?	Yes		No	
(If YES please provide details including what happens if the client does not take their medication):				

Information about Mental Health Medication		
Name of Medication	Frequency	Administration Route (e.g. depot/ oral etc.)

Are there specific triggers for the client becoming unwell? *(Please give details)*

What behaviours/signs indicate the client is becoming unwell? *(Please give details)*				
Are there any risks associated with their mental health?	Yes		No	
(If YES please provide details and add to risk section): *e.g. neglect, room management, ASB, violence*				

8. Physical Health

Clients current physical health needs *(please include nature and severity of the physical health need)*
Please give details of treatment client is currently receiving *(Please provide details and also include any contacts within the "support services involved in the clients current support" section):*
How is client managing at the moment?
Is the client taking medication? *(please provide details and how long they have been on this medication)*
What happens if the client does not take their medication?
How does their physical health impact on their day to day lives?
Does the client require ground floor accommodation? *(if YES how has this been assessed?)*
Does the client use mobility aids?
Are there any specific requirements in the accommodation with regard to physical health?

Are there any risks associated with their physical health issues? *(If YES rate as high, medium or low)*
(If YES please provide details and add to risk section):

Is the client in receipt of DLA or PIP?	Yes		No	
(If YES what rate of DLA / PIP are they claiming and is this related to their physical health?)				
Is the client using/have they used their DLA / PIP package to provide additional care?	Yes		No	
(If YES please provide details)				
Would the client be willing to use this money for a care package?	Yes		No	

Any other relevant information:

9. Offending History					
Client linked to Probation or Youth Offending Service?	Yes		No		
Please provide worker details *(Include how often the client needs to see this worker)*:					
Has the client <u>previously</u> been linked to Probation or Youth Offending Service?	Yes		No		
Please provide details of when this was and previous worker details:					
Has the client been convicted of any of these offences?					
Arson		Violence		Sexual Offence	
(If YES please provide details and dates)					
Has the client ever been a registered sex offender?	Yes		No		

(If YES please provide dates)

Is the client known to MAPPA? *(Multi-Agency Public Protection Arrangements)*	Yes		No	

Please indicate offence	

Please indicate Category/Level for the above offence					
Category One:		Category Two:		Category Three:	
Level One:		Level Two:		Level Three:	

Is client on any of the following orders? *Please attach any probation/Youth Offending Service documents and also include this information within the "supporting document checklist" section)*			
Suspended Sentence Order		Home Detention Curfew (HDC)/Tag	
Drug Rehabilitation Requirement		Anti-Social Behaviour Order (ASBO)	

License		Community Order		Referral Order	
Youth Rehabilitation Order		Intensive Supervision and Surveillance		Detention and Training Order	

(If Other please specify)

Date License/Order ends:	

Please list clients offending history including dates, sentences or community orders:
If probation documents are not attached please give reasons:

10. Support required to live independently			
	Always	Sometimes	Not at all
Personal care			
Accessing other Services			
Accessing education/training			
Accessing employment			
Applying for welfare benefits			
Paying rent and utility bills			
Independent living (cooking, cleaning, shopping)			
Literacy support			
Language and translation			

Taking medication			
Dealing with isolation			
Engagement with support			
Spending time with family and friends			
Looking after children			
Looking after partner, parent or other family members			
Cultural or spiritual activities			
Leisure activities			
If either "always" or "sometimes" is checked, please indicate what support is required:			

11. Financial Inclusion

Is the client in receipt of benefits?	YES		NO	
(Please include all benefits and the amounts where known)				
Has a claim for benefits been made and a decision pending?	Yes		No	
Does the client have a bank account?	Yes		No	
Does the client have access to online banking?	Yes		No	
Is the client currently in paid employment?	Yes		No	
If YES, please state the following • Name of employer • Length of time in employment • Hours per week • How much they earn per week (gross)				
Does the client have any savings	Yes		No	
(If YES please include details)				
Does the client have outstanding debt problems?	Yes		No	
Has the clients income been affected by changes to benefits?	Yes		No	
(If YES please include details)				
Is the client currently paying rent & service charge?	Yes		No	
Does the client have any rent/service charge arrears?	Yes		No	
(If YES please include details)				
Is there a payment plan in place?	Yes		No	
(If YES please include details and if client is complying)				

12. Support services involved in the clients current support		
Name/Type of service (e.g. GP/CMHT/YOS)	Contact Name	Contact details (address/tel./email)

13. Employment/Training/Education			
Employment/Education/ Training/Volunteering	From	To	Reasons for leaving

14. Serious Untoward Incidents & Safeguarding
Please use this space to detail any SUI's involving this client in the last 3 months and/or whether there are any safeguarding alerts in the last 12 months that may be relevant.

15. Clients Legal Status

This section should only be completed if the client is being referred into SHIP (i.e. do not complete if client is being referred to another provider within the pathway)					
Client's country of origin:					
Has the client lived outside of the UK within the last 5 years?	Yes:		No:		
If YES please provide dates and locations:					
When did the client arrive in the UK?					
Does the client have recourse to public funds?	Yes:		No:		
If YES please give details:					
What date did client start claiming benefits?					
Does the client have leave to remain? *(Please provide dates and expiry date)*					
Indefinite		Refused		Limited	
Are there any conditions attached to their leave to remain? *(Please give details):*					
Any other relevant information:					

16. Risk summary – please summarise the risks outlined in the assessment, please submit any other relevant risk documentation e.g. SLaM's risk assessment tools; Care Programme Approach information/OASYS/YOS/CPA/ etc. along with this PUARF form.

16.1

Identified Risk type	**Tick if applicable**	**Assessment of risk**
Risk to self		
Risk to Others		
Risk of abuse from others		
Schedule 1/Dangerous Offender/MAPPA client		
Verbal abuse		
Aggressive or intimidating behaviour		
Physical aggression/violence		
Non-Cooperation with staff		
Mental health		
Substance misuse		
Street activity		
Offending or anti-social behaviour		
Verbal abuse		
Damage to property		
History of rape or sexual assault		
Accidental fire setting		
Arson		
Lone working considered unsafe		
Female lone working considered unsafe		
Hoarding		
Please use the space below to specify any risk factors linked to the behaviours identified above:		

16.2 Details of Identified risk (Include details of last know incident & frequency of risk)

Please address the frequency, severity and pattern of behaviour,

16.3: Who is at risk? (Tick as many as apply and provide details where appropriate in the space provided)

Client	
Staff	
Visitors/Neighbours	
Contractors	
Specific individual(s) (specify)	

16.4: Risk Assessment Action Plan

Triggers / behaviour to be aware of

17. Client Consent
We need to obtain and share information about you with, and from a number of agencies to enable us to assist you effectively. In order to help you access housing and support services, we need your consent to access information about you from other agencies such as Housing Benefit, your GP, YOS, Probation etc… Information that you provide to SHIP (Single Homeless Intervention & Prevention) will also be shared with the services that we want to support you. In order to ensure your safety and the safety of others we will also complete a risk assessment which will be shared with any services that we want to provide you with support Information will be shared on a need to know basis, where there is a specific and legitimate need to know.
I …….. (print name) have checked the information on this form and agree it is accurate.

I understand and consent to the Pathway agencies obtaining information about me in order to make a full and accurate assessment of my situation.

I understand and consent to the information given to the Pathway agencies to be shared with other organisations and services.

Signed:…….

Date: ……

Witnessed by (Staff signature)	Staff Printed Name	Date

18. SUPPORTING DOCUMENTS CHECKLIST

Items 1 and 2 ***MUST*** *be provided as a minimum*

	Checklist items	**Attached**
1	Proof of identity and nationality (passport, birth certificate)	
2	Proof of income (wage slip, welfare benefits)	
3	Proof of current address (tenancy agreements, current utility bills)	
4	Psychiatric report	
5	Latest CPA report	
6	Community Care Assessment	
7	Occupational Therapy or other Health Assessment	
8	Medical Self-Assessment	
9	Probation/YOS Summary	
10	Other (Please specify)	