Disability FOCUS Referral Form

Application for (if known, please put a cross in the appropriate box)	
☐ Appointee	☐ Deputyship

Referrer Name:			
Referral Date:		**Contact Number:**	
Email Address:			
Occupation:			

Service User Information

Title:	First Name:	Middle Name:	Surname:

Date of Birth:	National Insurance Number:	**Status:** (delete as appropriate)
		Single/Cohabiting/Married/Divorced/Widowed/Other

If married or cohabiting, please provide their partners details below.

Partner Name:	Date of Birth:	NI Number:

Accommodation Details

Full Address and date moved to this address	
Previous Address (if applicable)	

Housing Category: (mark box with a X)	☐ Housing Association ☐ Private Landlord ☐ Residential Care ☐ Supported Living Accommodation	☐ Nursing Home ☐ Own Home ☐ Hospital ☐ Rehabilitation Unit
How is their accommodation funded? (mark box with a X)	☐ Self ☐ Local Authority - Does the client pay a contribution/top-up? ☐ NHS - Continuing health care ☐ NHS - Funded Nursing Costs ☐ S117 ☐ Deferred Payment ☐ Housing Benefit - please state the Local Authority that administers this	
If in residential or nursing home, is this an interim or long term placement?		

If the accommodation is rented please provide the Landlord's details below. Please provide a copy of the tenancy agreement.

Housing Association / Landlords Name :	
Address:	
Contact details:	

Property Type if owned	☐ House (Semi-detached) ☐ House (Detached) ☐ House (Terraced) ☐ Flat	☐ Apartment ☐ Bungalow ☐ Maisonette
Solely Owned/Joint Name(s) of owners		
Approx age of property:		

Welfare Benefit & Income Type	Amount	Payment Frequency (Weekly/Fortnightly/monthly)
Housing Benefit		
Council Tax Support		
State Pension (SP)		
Pension Credit (PC)		
Private or Occupational Pension		
Disability Living Allowance (DLA) **Care**		
Disability Living Allowance (DLA) **Mobility**		
Personal Independence Payment (PIP)		
Attendance Allowance (AA)		
War Widow's Pension (WWP)		
Income Support (IS)		
Job Seekers Allowance (JSA)		
Incapacity Benefit (IB)		
Employment & Support Allowance (ESA)		
Severe Disablement Allowance (SDA)		
Industrial Injury Disablement Benefit (IIDB)		

Widow's Pension (WP)		
Working tax credit		
Child Tax Credits		
Carers Allowance for someone they are caring for		
Is someone receiving carers allowance for the client?		Yes / No
Has the client ever received NHS funded care?		Yes / No
Have the client's care needs been assessed by the NHS?		Yes / No
Has the client ever had to pay towards the cost of their care (since April 2012)?		Yes / No
Is a care plan in place? If yes, please provide a copy, if no is one due to be undertaken?		Yes / No
Personal budget details (including amount of hours for care/support worker and any hours/money for other support such as attending day centre)		
Has a Financial Assessment been completed by the Local Authority (please give approximate date and provide a copy of the latest one.)		
GP Surgery:		
GP Address:		
GP Contact Number:		

Debts/Outgoings

Please identify any known debts (such as unpaid bills, any longer term debts that may have triggered the involvement of debt agencies)	
Does the client have home contents/buildings insurance? If so please provide details	
Yes/No	
Does the client have a funeral plan in place? If so please provide details	
Yes/No	
Client's current beliefs or religions:	

Care Provision

Who is currently providing the care for this client?	☐ Family ☐ External agency - in own home - Please provide details in box below ☐ Nursing or Residential Home Staff ☐ District or community nurses - Please provide details in box below ☐ Other please state
Care Agency Name:	
Address:	
Contact Name(s):	
Contact Number:	
Contact Email:	
How is care funded?	☐ Self ☐ Local Authority Funding - is client required to make a contribution? ☐ NHS - Funded Nursing Care ☐ NHS - Continuing Healthcare Care ☐ Other - please state

Assets and Capital

Please provide a copy of the latest statements for all bank/building society and post office accounts. Please supply where possible details of other capital and investments.

	Account details/reference numbers	Approximate balance/value
Bank Account:		
Post Office Account:		
Stocks or shares:		
Investments:		
Properties including their own home and investment rental properties: – please state		
Inheritance:		
Compensation:		
Other:		

Vulnerability/Disability Diagnosis

Please provide as much detail as possible in this section to help us assess if the client is accessing all the benefits and allowances that they are entitled to.

Family / Friends Contact Details

Has the referral been discussed with the client and their family or friends if applicable? Please provide contact details of family and friends

Other Information:

Please use this page to provide any additional information that may assist us with supporting this service user.

Please also refer to the accompanying Procedures and Policies Document as this will provide helpful information about our standard operating processes. Completed referral forms will be accepted as acknowledgement that this document has been read and understood.

Overview of Service Users Circumstances

Has a Capacity Assessment or best interest meeting taken place? If, yes what was the outcome? Please provide a copy.	
Yes/No	
Has the Client made a will? If yes, please provide the details of who holds the will? If no, has a full search been undertaken to ensure that a will is not place?	
Yes/No	
Is there a current Appointee, Lasting Power of Attorney or Deputy in place? If yes, please state who and have they agreed to relinquish?	
Yes/No	
Has any legal order been made from the Mental Health Act or the Mental Capacity Act including Deprivation of Liberty (DoL)? Please provide details	
Yes/No	
Is the client part of a current safeguarding process as a result of concerns?	
Yes/No	
Has the client experienced fraud or financial scamming?	
Yes/No	