**Arrangement of Care and Support Service**

**Referral Form**

Please complete this form if you identify an individual who is eligible for a service from the Local Authority or Integrated Care Board (ICB), or who would like further information/support. It is important that you complete the form with as much information as possible for us to be able to provide them with the appropriate support and guidance.

**Please note referrals will not be progressed unless all appropriate information in the form is completed.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Referral date | |  | | | | | Liquid Logic or Broad Care ID | |  | |
| NHS Fast Track | | | | Yes | | | No | | | |
| **1.** | **Client Details** | | | | | | | | | |
| Name | |  | | | | | Date of Birth | |  | |
| Address | |  | | | | | Postcode | |  | |
| Contact Number | |  | |
| Email | |  | | | | | | | | |
| Communication Support:  (e.g. interpreter required, pictorial) | | | | | |  | | | | |
| Does the person have capacity to make decisions about their care and support? | | | | | | Yes  No | | If NO, complete Suitable Persons form below. | | |
| **2.** | **Referrer Details** | | | | | | | | | |
| A named Social Worker or ICN is preferable please note that if the referral is from the Duty Team, then all correspondence will be sent to the Duty Team unless advised otherwise. | | | | | | | | | | |
| Name | | |  | | | | Contact Number | |  | |
| Position/Team | | |  | | | | Organisation | |  | |
| Email | | |  | | | | | | | |
| **3.** | **Support Plan** | | | | | | | | | |
| Referral Type | | Self-funder | | | | | Short Stay | | | |
| Personal Health Budget | | | | | Direct Payment | | | |
| Carer Direct Payment | | | | | Other: | | | |
| What outcomes are to be achieved?  (i.e. reduce social isolation, preventing carer breakdown etc) | |  | | | | | | | | |
| What support is being requested? (i.e. What can the funding be used for?) | |  | | | | | | | | |
| Support required | | Accessing the Community including shopping | | | | | Other: | | | |
| Meal Support | | | | |
| Personal Care Support | | | | |
| Is specialised support required e.g. peg feeding, Ventilation, Tracheostomy SALT support, aerosol procedures? | | | | | No  Yes, please specify: | | | | | |
| Any environmental risks to be considered when contacting or visiting clients, e.g. pets, smokers, accessing the home, history of violence. | | | | | No  Yes, please specify: | | | | | |
| Is a joint visit required: (With ICN, social worker, two advisors) | | | | | No  Yes, please specify: | | | | | |
| **4.** | **Supporting Documents** | | | | | | | | | |
| If applicable, please indicate which documents have been attached for use in arranging appropriate support: | | | | | | | | | | |
| Decision Support Tool – **essential for PHB** | | | | | | | Care Plan | | | |
| Care Act Assessment – **essential for Short Stays** | | | | | | | Provider Report | | | |
| Nursing Needs Profile | | | | | | | Other: | | | |
| Online Financial Assessment (OFA) | | | | | | |
| **5.** | **Finance** | | | | | | | | | |
| Please indicate how the support requested will be funded. In cases where Social Care funding is involved, a minimum of an online financial assessment is required to progress referral. | | | | | | | | | | |
| **Funding Source** | | CHC | | | | Social Care | | | | Self-funding (move to section 6) |
| Joint Funded CHC/Social Care: / | | | | | | | |
| **Social Care Funded** | | Hours Funded and Rate agreed | | | |  | Has the client been requested to complete the Online Financial Assessment?\*\* | | |  |
| Personal Contribution | | | | £ | Date Referred to Client Finance | | |  |
| **CHC Funded** | | Indicative Budget | | | | | £ | | | |
| **6.** | **Consent** | | | | | | | | | |
| I have read and understood how you will use and process my data for this service and I have informed any relevant third-parties of the information I provide to you about them, in line with the [privacy notice](https://disabilitypositive.org/privacy-policy/). | | | | | | | | | | |

**Please return completed forms to:** [**triage@disabilitypositive.org**](mailto:triage@disabilitypositive.org)

**Tel: 03333 660107**

**\*\*Disability Positive can only support once an Online Financial Assessment or Full Financial Assessment by Client Finance is completed.**

**If client has been requested to complete the OFA, the advisor will ask for this upon initial contact. If not available, the case will be put on hold until the figure can be provided.**

**Arrangement of Care and Support Suitable Persons Authorisation Form**

The Arrangement of Care and Support Service promotes choice, control and independence. We work with you and your family to assist with the planning and arrangements of your care or support package.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1.** | **Client Details** | | | |
| Name | |  | Liquid Logic or Broad Care ID |  |
| **Suitable Person Authorisation** | | | | |
| **I would like to nominate a person** (whose details are below) to liaise with the Arrangement of Care and Support Service provider(s) regarding the organisation of my care and support package, and managing the Direct Payment finances.  **Or**  **Individual has been deemed to lack capacity around their care and support choices.** A third party (whose details are below) has been authorised to liaise with the Arrangement of Care and Support Service provider(s) regarding the organisation of the individual’s care and support package, and managing the Direct Payment finances. | | | | |
| **1.** | **Third Party** | | | |
| Name | |  | Relationship to Client |  |
| Address | |  | Postcode |  |
| Contact Number |  |
| Email | |  | | |
| Power of Attorney | | Yes  No | | |

**Third Party Consent**

In order to help you, we need to store information about you. As some of this information is deemed sensitive (e. g. information about your health) under the Data Protection Act 1998 and the General Data Protection Regulations 2018, we require your consent to process this information.

I have read and understood how you will use and process my data for this service and I have informed any relevant third-parties of the information I provide to you about them, in line with the [privacy notice](https://disabilitypositive.org/privacy-policy/).

Signed Date

**Please return completed forms to:** [**triage@disabilitypositive.org**](mailto:triage@disabilitypositive.org)

**Early Tel: 03333 660107**