Together Home

High Needs Support Package

High Needs Panel Referral Form

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| Please return to: highneedspackage@homelessnessnsw.org.au  |
| Section 1 | Name and contact details of person making referral |
| **Name** |    |
| **Job title** |    |
| **Organisation** |  |
| **District**  |   Choose an item. |
| **Email** |  |
| **Telephone** |  | **Date Referred**  | Click or tap to enter a date. |
| Community Housing Provider | Choose an item. |
| Additional contact and email address for person responsible for managing invoices on behalf of CHPName:Position:Email: |
| **Engagement with frontline services**Select **ONE** statement that best applies to the individual being referred:In the last month they:

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|[ ]  Rarely missed an appointment.  |
|[ ]  Usually kept appointments and routine activities; followed through with reasonable requests, engaged in accessing other services.  |
|[ ]  Followed through some of the time with daily routines or other activities; sometimes followed through with reasonable requests; minimally involvement with other services. |
|[ ]  Were irregular with routine activities or rarely engaged with reasonable requests, though kept some appointments. |
|[ ]  Did not engage at all or keep appointments  |

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| Section 2  | **Individual details**  |
| **NAME:** | **D.O.B:** |
| **CLIENT ID** | **THCI:** | **SLK:** |
| **Current VI-SPDAT Score**  |   | **Previous VI-SPDAT score** |  |
| **TOGETHER HOME START DATE** |  | **TOGETHER HOME TRANCHE** |  |
| **Individual identifies as Aboriginal and/or/both Torres Strait Islander** | **Yes** [ ]  **No** [ ]  |
| **Individual identifies as Aboriginal and/or/both Torres Strait Islander and over 45 yrs** | **Yes** [ ]  **No** [ ]  |
| **Individual identifies as LGBTQI+A** | **Yes** [ ]  **No** [ ]  |
| **Female** | **Yes** [ ]  **No** [ ]  |
| **Female under 24 yrs.** | **Yes** [ ]  **No** [ ]  |
| **Individual over 55 yrs.**  | **Yes** [ ]  **No** [ ]  |
| **Current living situation**Rough Sleeping **Yes** [ ]  **No** [ ] Temporary Accommodation **Yes** [ ]  **No** [ ] Transitional Housing **Yes** [ ]  **No** [ ] Housed **Yes** [ ]  **No** [ ] Living in overcrowded housing **Yes** [ ]  **No** [ ] Other (please provide details)  |

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| Section 3 | Reason for referral |
| Length of time cycling between homelessness and temporary accommodation | \_\_\_\_weeks/\_\_\_\_\_months/\_\_\_\_\_years |
| VI-SPDAT score is less than 15 but individual has chronic at-risk health conditions that requires urgent review.If answer is ‘No’ please discontinue referral | **Yes** [ ]  **No** [ ]   |
| Mental Wellbeing  |  |
| Physical Health  |  |
| Substance Use  |  |
| Current risk to tenancy |  |
| Other  |  |

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| Section 4 | Summary of risks |
|  | Current(last 2 weeks) | Recent Past(last 6 months) | Historical Past(over 6 months) |
| Self-Harm |[ ] [ ] [ ]
| Harm to others |[ ] [ ] [ ]
| Suicidal thoughts/intentions |[ ] [ ] [ ]
| Physical/sexual/emotional abuse |[ ] [ ] [ ]
| Significant medical needs/Disability |[ ] [ ] [ ]
| Alcohol/Drug use |[ ] [ ] [ ]

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| Section 5 | Referral History  |
| **NDIS**  [ ]  Current [ ]  Previous referral | Provide details to any barriers encountered when making referral to this service |
| **Mental**  [ ]  Current**Health** [ ]  Previous referral | Provide details to any barriers encountered when making referral to this service |
| **HASI** [ ] Current [ ] Previous referral | Provide details to any barriers encountered when making referral to this service |
| **GP**  [ ]  Current [ ]  Previous referral | Provide details to any barriers encountered when making referral to this service |
| **Drug &** [ ]  Current**Alcohol** [ ]  Previous referral**Service** | Provide details to any barriers encountered when making referral to this service |
| **Other** [ ] Current  [ ]  Previous referral | Provide details to any barriers encountered when making referral to this service |
| Please provide details to any barriers encountered when making referrals to this service |

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| Section 6 | Consent Statement for information sharing with the High Needs Panel |
| If you believe the client has consented to this referral via an alternative consent form, please provide proof of this consent here.If you have not received the client’s consent to be referred for consideration for higher support funding, please completed the following with the client.  **I understand the information that is recorded on this form and agree to it being shared with the High Needs Panel for the purpose of providing services to me. I have agreed to sharing information with the services listed below.****Name**  **Date****Signed***Or* Verbal consent **Yes** [ ]  **No** [x] Audio consent attached **Yes** [ ]  **No** [ ]   |

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| Section 7 | Additional Information Checklist |  |
| Individual has provided consented to a referral to the High Needs Panel?  | **Yes** [ ]  **No** [ ]  |
| TH client engagement and Nomination form (attached) | **Yes** [ ]  **No** [ ]  |
| HNP Budget: Required Support services and costs (attached)  | **Yes** [ ]  **No** [ ]  |
| VI-SPDAT Score provided  | **Yes** [ ]  **No** [ ]  |

Together Home

High Needs Support Package

High Needs Panel

Budget Template

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| --- | --- | --- | --- |
| Individual Name |  | Individual ID |  |
| D.O.B | Click or tap to enter a date. | Date Referred | Click or tap to enter a date. |
| Referring Agency |  | District  | Choose an item. |

Current support package

Include existing support under Together Home and other support systems, as well as any existing HNP funding in the case of reviews.

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| **Need** | **Intervention** | **Frequency** | **Service Provider** | **Fees per encounter/service** |
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Additional package requirements

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| **Need** | **Outcome criteria** | **Intervention** | **Frequency** | **Service Provider** | **Fees per encounter/service** | **Duration of service provision**  | **Total** |
|  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |
| **TOTAL** |  |

Long term plan – transition to mainstream service provision

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| **Goal**  | **Action** | **Stage (by when)** |
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