

HOMELESSNESS MENTAL HEALTH PROGRAM

Illawarra Shoalhaven Local Health District

Updated 2020

Referral form

The Illawarra Shoalhaven Homelessness Mental Health Program supports clients **aged 18 years and over, who are homeless or at risk of homelessness (inc. tenancy at risk), and have been diagnosed with a mental health condition.** The program assists clients establish secure accommodation and avoid homelessness. This is achieved with co-case management and flexible brokerage supports.

This form is to be completed by referring agency (either non-government or government funded) for:

- **Co-Case Management** (Section A)
Work with the referrer by providing education, information and support to improve client's accommodation and mental health outcomes.
- **Brokerage** (Section B)
Funding is available to purchase items/ services that will secure current accommodation or help reallocate more appropriate accommodation.

Guide to completing the form:

1. Referral to be completed by referrer (not client).
2. Discuss consent with client before checking consent given box
3. Save a copy for your records.
4. Submit form to ISLHD-HMHPProgram@health.nsw.gov.au using submit button (pg5).

Referrers will be notified when a referral has been received.

For further information please contact:

Homelessness Mental Health Program
Roslyn Poole and Catherine Rogers

P: 4253 4500

E: ISLHD-HMHPProgram@health.nsw.gov.au



Section A – REFERRAL INFORMATION FOR CO-CASE MANAGEMENT
(this section must be completed)

1. Referring Agency

Date: _____ Name of referring Agency: _____
 Name and role of referring person: _____
 Phone: _____ Email: _____

2. Client Information

Client Name: _____ DOB: _____ Age: _____
 MRN: _____ Phone: _____
 Gender: Female Male Non-binary Other Didn't wish to disclose
 Address: _____
 Does client identify as Aboriginal or Torres Straight Islander? Yes No
 Is an Interpreter required? Yes No

3. Presenting Issues

Current accommodation:

Improvised Dwelling <input type="checkbox"/> <i>(e.g. sleeping rough, tent, car, bush)</i>	Public/Social Housing <input type="checkbox"/>
Short Term Accommodation <input type="checkbox"/> <i>(e.g. couch surfing, refuge, motel, temporary accom)</i>	Private Rental <input type="checkbox"/>
Low Standard Accommodation <input type="checkbox"/> <i>(e.g. caravan park, boarding house)</i>	Other <input type="checkbox"/> <i>(e.g. group home, hospital, prison, own home, aged care)</i>

Does the client have a Tenancy at Risk? Yes No

Mental Health: Diagnosis: _____

Mental Health history: _____

4. Fortnightly income details? \$ _____ **Source:** _____
Benefit type: _____

5. NDIS application Yes No
 If yes: Status: Accepted Rejected Processing
 Activated: Yes No



6. Information relating to the client's situation:

Please provide as much information as possible (i.e. present situation, past homelessness, chronic health issues, drug and alcohol issues, debt, budgeting and expenditure) to support your referral.

7. Do you agree to maintain contact with this client while the referral is being processed? Yes No
If no, who will be the contact person/service?



8. **Does the client receive support from any other agency?**

Yes No

If yes, which agency/s:

9. **Has the client previously received brokerage from any other agency?**

Yes No

If yes, please give details:



Section B – BROKERAGE

(this section must be completed for brokerage applications only)

PLEASE NOTE: Each brokerage application will be assessed by the Brokerage Committee for approval

1. Brokerage items requested: *(fill in below).*

2. Please outline the steps you are making to reduce the risk of homelessness and improve the mental health of the applicant. Please include a care plan and explain how brokerage will improve their current situation.

3. Are there any other sources of financial assistance for this and, if so, what attempts have been made to obtain assistance?

Timeframe: If the application is for assistance with moving costs/furniture etc. We need a clear time frame for housing/offer of housing.



Section C - CONSENT

This consent form is to be discussed with the client and completed by the referrer.

1. **Is the client capable of informed consent?** Yes No If consent for this referral has not been given - or if the client is not capable of giving informed consent - on what grounds has the decision been made to proceed?

2. **Is the client aware of the referral to the program?** Yes No

3. **Does the client consent to share this information?** Yes No
Note: Consent is for information to be shared with relevant agencies whose service relates to this referral. The client may also request that information not be shared. If this is the case please indicate which agency/agencies should be excluded.

4. **Does the client agree to a follow up phone call regarding their referral to the program?** Yes No

Consent has been given by client to submit this referral.

Note: Clients have the right to:

- Be told why information is being collected and how the information will be used;
- Receive any additional assistance to understand what consent entails;
- Be told who will have access to the information.

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