**Youth Homelessness Prevention Service**

**Referral Form (young people aged 11-25 years)**

1. **Young Person details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** | **Miss** [ ]  **Ms** [ ]  **Mrs** [ ]  **Mr** [ ]  | **Name** |  |
| **DOB/Age** |  | **Gender** |  |
| **Nationality** |  | **Preferred Language** |  |
| **Any disability?**  | **Yes** [ ] **No** [ ]  | **If yes give details:** |  |

1. **Address & contact details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Current Address**  |  | **Post Code** | **Is young person No Fixed Abode or a Rough Sleeper? Yes** [ ]  **No** [ ]  |
|  |
| **Home Tel.** | **Mobile Tel.** | **Email Address**  |
|  |  |  |
| **Preferred method of contact OR alternative contact details** | **Home phone** [ ]  **Mobile** [ ]  **Email** [ ]  **other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

1. **Concerns identified**

|  |  |
| --- | --- |
| **Indicators of potential risk of homelessness – please tick if relevant to the young person** |  |
| * **Not attending school/excluded from school**
 |  |
| * **Involvement in criminal justice system**
 |  |
| * **Running away/going missing for one night or more**
 |  |
| * **Neglect**
 |  |
| * **Substance misuse – Tier 2/3/4**
 |  |
| * **Domestic abuse/violence in the family home**
 |  |
| * **Mental health concerns (parents and/or young person)**
 |  |
| * **Older siblings previously presenting as homeless at a young age.**
 |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Does the young person have any communication issues?** |  | Is an interpreter /signer required?  | **Yes**[ ]  **No**[ ]  |
| **Are there any cultural issues we should be aware of?** |  |
| **Does the young person currently have any source of income?** |  |
| **Does the young person have any dependents which rely on them?**  |  |
| **Does the young person have any known risks which may affect the way they work with us? (risks to self or others)** |  |
| **Does the young person have any medical/health (incl. mental health) issues which we should be aware of?** | Current mental health support [ ]  previous mental health support [ ]  None [ ]  |

1. **Other details**
2. **Any other information you feel is relevant**

|  |
| --- |
|  |

1. **Doctors information**

|  |  |  |
| --- | --- | --- |
| **Doctor’s**  | **Surgery Address** | **Contact Name and number** |
|  |  |  |

1. **Current / Previous Support Received (Are any other agencies involved with any members of the household?)**

*(If known) please detail any previous/other current housing-related support received by applicant (floating or supported housing) including any exclusions*

|  |  |  |
| --- | --- | --- |
| **Agency** | **Contact Name and number** | **Details of support provided (if known)** |
| School/College |  |  |
|  |  |  |
|  |  |  |

1. **Consent – If you do not have consent from the young person to send this referral it will not be accepted**

|  |
| --- |
| Has the young person consented to you sending this referral?  Yes [ ]  No [ ]  |
| Is parent/carer aware of referral? And any considerations regarding this, please give details?  Yes [ ]  No [ ]  |

1. **Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Referrer** |  | **Date**  |  |
| **Position** |  | **Agency** |  |
| **Contact Number** |  | **E-mail** |  |

Where possible this form should be signed by the young person. If the young person has not signed this form the referrer must state that verbal consent has been given for a referral to be made.

|  |  |  |  |
| --- | --- | --- | --- |
| **Young Person’s Signature**: |  | **Date:** |  |
| Or applicant’s verbal consent to referral: Yes [ ]  No[ ]   |
| **Referrer’s Signature:** |  | **Date:** |  |

**Please return completed referrals to:**

 Gwasanaeth Atal Digartrefedd Ymhlith Ieuenctid Wrexham, Canolfan Pobl Ifanc Fictoria, 13  Stryt yr Allt, Wrecsam,  LL11 1SN

   Wrexham Youth Homeless Prevention Service, The Victoria Young People’s Centre, 13 Hill Street, Wrexham LL11 1SN

  01978 317955 Email: YHPS@wrexham.gov.uk

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