REFERRAL FOR SHEFFIELD DIRECT PAYMENT SUPPORT SERVICE

(For new and existing Direct Payment recipients)

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| **Date of referral/contact**: |   | **Individual’s Liquid Logic number:** |  |

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| **Is this a Self-Referral?** | Yes [ ]  No [ ]  |
| **Date:**   **Time:**  **Location:**  |
| **How did they contact the service?** | [ ]  Advice line (phone or email) [ ]  Office-drop-in [ ]  Community drop-in [ ]  Other, please detail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Self-Referral, if applicable

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| **Individual’s details** |
| **Name**: |  |
|  **DP recipient** [ ]  **Suitable Person** [ ]  **PA** [ ]  |
| **Address**:**(Including post code)** |   |
| **Mobile number**: |  | **Landline**: |  |
| **Email**: |  | **Date of birth**: |  |
| **Ethnic origin**: |  | **Gender**: |  |
| **Preferred****language**: |  |

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| **Services Required or Requested** |
| **Support with management of DP**  [ ]  | **Employer Support**  [ ]  | **Peer support (DP)**  [ ]  |
| **Support with recruitment**  [ ]  | **Support to find a PA**  [ ]  | **Peer support (PA)**  [ ]  |
| **Support to manage own money**  [ ]  | **Support to manage payroll** [if already set up, with whom?] [ ]  | **Setup of Employers Liability Insurance**  [ ]  |
| **Other** (please provide details): |

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| **Does the individual prefer that a Suitable Person deal with enquires?** | **Yes**  [ ]  | **No** [ ]  |

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| **Suitable Person details (if applicable)** |
| **Name**: |  |
| **Address**:**(Including post code)** |   |
| **Mobile number**: |  | **Landline**: |  |
| **Email**: |  |

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| If **‘Yes’,** please advise on the nature of the relationship to the individual: |   |

**Professional Referrer’s details, if applicable** |
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| **Name**: |  | **Job title**: |  |
| **Team**: |   |
| **Address**:**(Including post code)** |  |
| **Email**: |  | **Contact number**: |  |

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| **Do you wish to attend the first meeting?****(face to face or virtual)** | **Yes**  [ ]  | **No** [ ]  |

**If a self-referral, follow up with Duty Team to confirm this information. If it is a professional referral, complete with referrer at the time.**

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| **Amount or number of hours of Direct Payment to be used for PA/employer element and hourly rate?** \*\*this may not be the full support plan\*\* |  **£** **Please attach a copy of the completed DP Calculator and if applicable, a completed PA Rates Tool with this referral form.** |

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| **Ability**  |
| **Can this person manage the Direct Payment paperwork and also manage any staff, if they plan to employ?** | **Yes**,on their own [ ]  | **Yes**, with support [ ]  |
| **No**, a Suitable Person has been identified(See details above) [ ]  |

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| **Have the roles and responsibilities of managing the direct payment been explained and understood?** | **Yes**  [ ]  | **No** [ ]  |

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| **User groups** |
| **Adults**  [ ]  | **Mental Health** [ ]   | **Sensory Issues** [ ]  | **Learning Disability** [ ]  |
| **Child**  [ ]  | **16- to 17-Year-Old** [ ]  | **Carer** [ ]  |

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| **Communication requirements etc.** |
| (For e.g. All contact to be made through mum) |

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| **Relevant Information on health and safety and other special arrangements** |
| **None known**  [ ]  | **No lone Male**  [ ]  | **No lone Female** [ ]  |
| **Do not visit alone** [ ]  | **Dangerous pet** [ ]  | **Translator required** [ ]  |
| **Other** (please provide details): |

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| **Additional Information** |
| Please give a brief general overview of the individual’s situation. Please indicate if this is a new or existing Direct Payment? |