BEYOND HOUSING

SHASP INTEGRATED CASE MANAGEMENT REFERRAL FORM

REFFERAL TYPE	
DATE OF REFERRAL	
SEGMENT	
ALLOCATION TYPE	

CLIENT CONSENT FOR REFERRAL	
SAFETY ALERT	If Yes, refer to background section

TENANT/APPLICATION DETAILS

TENANT/APPLICANT NAME:	DATE OF BIRTH:
ADDRESS:	SUBURB:
HOUSEHOLD TYPE:	POSTCODE:
CONTACT NUMBERS:	GENDER:
EMAIL ADDRESS:	NUMBER OF CHILDREN:
ARE YOU REFERRING OTHER HOUSEHOLD MEMBERS?	INCOME TYPE:
PREFERRED LANGUAGE:	INTERPRETER REQUIRED?
COUNTRY OF BIRTH:	IS THE TENANT ABORIGINAL OR TORRES STRAIT ISLANDER?
NEXT OF KIN:	NEXT OF KIN CONTACT No:

HOUSEHOLD MEMBERS

NAME	DOB	AGE	INDIGENOUS /CALD	GENDER	RELATIONSHIP	TENANCY STATUS	PHONE

DHHS HOUSING STATUS

ACCOUNT/APPLICATION No: TENANCY START DATE:	CURRENT ACCOUNT STATUS: (REFERRALS AT WARRANT APPLICATION - DISCUSS WITH HSM FIRST)
CURRENT ISSUES:	ARREARS AMOUNT:
VCAT DETAILS :	LAST ACTION:

ELIGIBILITY TRIGGERS (prioritising) Please tick as many as appropriate.

- ☐ are in crisis and are at imminent risk of losing their tenancy
- ☐ have been given a Notice to Vacate
- ☐ have a scheduled VCAT hearing
- ☐ are currently in rental arrears
- ☐ are not involved in other services
- ☐ do not have the capacity to self manage
- ☐ have children or young people living with them who are likely to be at risk if the tenancy breaks down
- ☐ have recently (within the last six months) exited from SHASP services and who are re-referring
- ☐ have multiple indictors that suggest they are vulnerable to the risk of tenancy breakdown.

HOUSING SUPPORT NEEDS

- ☐ prior and/or current debt
- ☐ financial including rent arrears, budgeting problems and/or loss of income
- ☐ gambling
- ☐ history of housing instability/ homelessness
- ☐ household factors (social isolation, social instability)
- ☐ intellectual disability
- ☐ acquired brain injury
- ☐ substance misuse
- ☐ antisocial behaviour
- ☐ mental illness currently not managed
- ☐ diagnosed psychiatric illness
- ☐ physical/sensory disability
- ☐ other health issue
- ☐ cultural factors (communication barriers)
- ☐ poor living skills
- ☐ relationship issues e.g. family breakdown
- ☐ family/domestic violence, history of abuse
- ☐ compulsive behaviours
- ☐ history of disputes
- ☐ no response to a contract review
- ☐ failure to maintain the property (e.g. hoarding, squalor)
- ☐ overcrowding
- ☐ Moving into a new area without adequate supports.
- ☐ recently left institution
- ☐ contact with multiple agencies, including frequent use of emergency services

SUPPORT AGENCIES INVOLVED

Agency	Contact Name	Phone Number	Current Consent	Support end date

BACKGROUND / CASE NOTES (Please ensure that case notes are provided for each 'ticked' support issue)

CHECKLIST

☐ Signed form of authority ☐ Rental account statement ☐ VCAT order ☐ Safety alert

☐ Relevant case notes ☐ Photos ☐ Breach notes

PLEASE ENSURE TENANCY FILE HAS ALL RECENT ACTIONS DOCUMENTED

RECOMMENDATION & APPROVAL

REFERRED BY: **TELEPHONE:**

POSITION:

DATE:

APPROVED BY: **TELEPHONE:**

POSITION: **HOUSING SERVICES MANAGER**

DATE:

REFERRAL OUTCOME

Referral accepted ☐ Approved

☐ Not approved

☐ Wait listed

Reason for non acceptance

Date:

Form of Authority

For release of information to the Department of Health and Human Services (DHHS) (housing) and BeyondHousing

I/We ____ (Name)

of ____

agree to be referred to the Social Housing Advocacy and Support Program (SHASP), provided by BeyondHousing for support to my tenancy. I am aware that the information on this document will be provided to the SHASP staff at BeyondHousing and this service has been explained to me by the referring organisation. I hereby give permission to the SHASP program to use the information on this form to assist with my housing and for data collection purposes. I have been advised that this referral does not guarantee me of support as it is dependant on available positions in the program.

I agree for all relevant information to be shared between DHHS and BeyondHousing's SHASP program as part of this referral and if an allocation occurs.

Signed ____________________ Witness ____________________

Date ____________________ Date ____________________

Verbal Consent: Yes/No
File Note confirmation recorded in HiiP on ____________ (Date)

Privacy Disclaimer: This SHASP Referral Form contains confidential information intended only for the purposes of referring a person/household to the SHASP Agency in the aim of establishing appropriate support requirements required to sustain the person/households tenancy. The referral is only to be made where a client has given prior consent; **OR** pursuant to Information Privacy Principle - Schedule 1, s2.1 (d) (i) of the *Information Privacy Act 2000*. The form is only used by DHHS employees for this specific purpose, and is not for disclosure to any other external parties. The information is stored securely on the tenancy / application file. Without this information we would be unable to ensure that DHHS Policies & Procedures have been correctly applied or that the DHHS has made all attempts to ensure the success of the persons/households tenancy