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): | | |  |  |  |  | | --- | --- | --- | | **Does the individual prefer that a Suitable Person deal with enquires?** | **Yes** | **No** |  |  |  |  |  | | --- | --- | --- | --- | | **Suitable Person details (if applicable)** | | | | | **Name**: |  | | | | **Address**:  **(Including post code)** |  | | | | **Mobile number**: |  | **Landline**: |  | | **Email**: |  | | |  |  |  | | --- | --- | | If **‘Yes’,** please advise on the nature of the relationship to the individual: |  |   **Professional Referrer’s details, if applicable** | | | | |
|  | | | |
| **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? |