

Spirit Referral

Self referral	<input type="checkbox"/>
Agency referral	<input type="checkbox"/>
Additional sheets attached	<input type="checkbox"/>
Date referral received	
Referral number	

Dear applicant

Spirit provides a CO-Dependency Addictions Treatment programme that helps service users address many and varied issues. For a comprehensive list of issues worked with please visit <http://www.spirit-online.co.uk> The website details all aspects of Spirits program, referral process and lists ways to get in touch with us. The information we collect from this form is subject to Spirits confidentiality policy.

We may need to request information about you from any other agencies that work with you. This will help us to fully assess your application to Spirits Treatment Program. We will ask you for your consent before we do this.

Applicant's name	
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Service details (To be completed by the office)			
Service name			
Contact			
Address			
Post code			
Telephone number		Fax number	
Service type	Counselling		
	Treatment		

Referrer details (if applicable) Note: also complete the separate referral form			
Referral agency			
Contact name			
Email address			
Telephone number		Fax number	

Your details

Address			
Postcode		Contact telephone No.	
N.I. Number		Nationality	
Date of birth	Age	Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Do you need someone to sign for you?	No <input type="checkbox"/> Yes <input type="checkbox"/>		
Do you need information in Braille?	No <input type="checkbox"/> Yes <input type="checkbox"/>		
Do you need an interpreter?	No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, which language?		

Your housing

When did you move into your current address?			
Is your current housing status:	Temporary <input type="checkbox"/>	Permanent <input type="checkbox"/>	Homeless <input type="checkbox"/>
Current landlord (if applicable)			
Local authority area			
Are you on a local housing register?	No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, which one?		
Do you have any pets?	No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, what type(s)?		
Details of family living with you (if you need more room please attach a separate sheet)			
Name(s)	Date of birth	Age	Relation to you
☺			
☺			
☺			
☺			
Where have you lived for the past three years? (Include any hospital or prison stays)			
Address	From	To	Reason for leaving
Do you have any problems in your current accommodation?			No <input type="checkbox"/> Yes <input type="checkbox"/>
If yes, please give brief details:			

About you (This will help us to make an assessment of your needs)

Are you dependent on alcohol/substances/prescription medication Yes No

Do you consider yourself to have a disability? Yes No

- If yes please give details

- Could your disability stop you entering a building e.g. climbing stairs? Yes No

- If yes, please give details

Are you experiencing, or have you in the past experienced problems with depression, anxiety, self-harm or other mental health issues? Yes No

Are you experiencing, or have you in the past experienced problems with self-harming? Yes No

Are you currently using any prescribed drugs? Yes No

Do you have any convictions for arson? Yes No

Do you have any other convictions/cautions/warnings against you? Yes No

- If yes, please give details

Are you experiencing, or have you in the past had problems with being violent or aggressive towards others? Yes No

Do you have an anti-social behaviour order (ASBO) against you? Yes No

- If yes, please give details

Are you experiencing domestic abuse? Yes No

Do you need support with legal matters not related to offending behaviour? Yes No

Are there any other areas you would like support with? Yes No

- If yes, please give details

Please give detail of agencies working with you, or people who help to support you
(E.g. doctor, social worker, probation officer, community psychiatric nurse, advocate, family, friend)

Name(s)	Job title	Contact address	Telephone no.

Your support needs (Please tick all the boxes for things where you need more support)

Housing	Keeping your room/home safe, clean and tidy <input type="checkbox"/>	Past or present problems with neighbours <input type="checkbox"/>
	Notices or evictions <input type="checkbox"/>	Arranging repairs <input type="checkbox"/>
	Rent arrears <input type="checkbox"/>	Other (state) <input type="checkbox"/>
Finance	Paying rent <input type="checkbox"/>	Claiming benefits <input type="checkbox"/>
	Paying bills <input type="checkbox"/>	Clearing debts <input type="checkbox"/>
	Budget planning <input type="checkbox"/>	Other (state) <input type="checkbox"/>
Support networks /family/friends	Family links <input type="checkbox"/>	Friends <input type="checkbox"/>
	Other social networks <input type="checkbox"/>	Isolation <input type="checkbox"/>
	Domestic abuse <input type="checkbox"/>	Offending <input type="checkbox"/>
	Behaviour management <input type="checkbox"/>	Other (state) <input type="checkbox"/>
Meaningful use of time	Training <input type="checkbox"/>	Education <input type="checkbox"/>
	Employment <input type="checkbox"/>	Interests <input type="checkbox"/>
	Literacy needs <input type="checkbox"/>	Help with language <input type="checkbox"/>
	Accessing childcare <input type="checkbox"/>	Other (state) <input type="checkbox"/>
Diversity	Cultural needs <input type="checkbox"/>	Religious needs <input type="checkbox"/>
	Personal preferences <input type="checkbox"/>	Other (state) <input type="checkbox"/>
Physical health and wellbeing	Getting a doctor <input type="checkbox"/>	Diet <input type="checkbox"/>
	Exercise <input type="checkbox"/>	Hygiene <input type="checkbox"/>
	Getting support from other agencies <input type="checkbox"/>	Other (state) <input type="checkbox"/>
Pregnancy <small>(For women applicants only)</small>	Are you pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If yes, what is the baby's due date?	

Your financial situation

Do you have any rent arrears Yes No

If yes, please give details, including any agreements you have made to repay the debt?

Please tell us what benefits you currently claim/ receive (tick all that apply)

Income Support	<input type="checkbox"/>	Job seekers allowance	<input type="checkbox"/>	Housing Benefit	<input type="checkbox"/>
Disability living allowance	<input type="checkbox"/>	Severe disability allowance	<input type="checkbox"/>	Incapacity Benefit	<input type="checkbox"/>
Other (state)	<input type="checkbox"/>				

Are you working? Yes No

If yes: How many hours do you work a week?
What are your weekly earnings?

Are you in education or on a training course? Yes No

If yes: What course are you doing?
what hours do you do

Do you do any voluntary work? Yes No

If yes: What hours do you do?

Do you have any savings over £3,000? Yes No

If yes, please can you give us more detail as this might affect your ability to claim certain benefits?

Your goals in Therapy

Please can you tell us about your goals that you hope to achieve through therapy

Declaration

I confirm that the information I have given is correct. I understand that if any information I have provided is found to be false you may withdraw any offer of treatment.

Signed (applicant)		Date	
Print name			

Your consent to contact your referral agency about this application (Please sign if you are applying with the support of a referral agency)

I give my permission for staff at Spirit to discuss this application and all the information I have provided in this form with the referral agency named on the front of this form.

Signed		Date	
Print name			

Thank you for completing this application form

Monitoring

Please can you also complete the monitoring form attached. The information you provide helps us to monitor our policies to ensure they are fair and promote access to all those who need our services.

Monitoring information does not form part of the decision making process. You do not have to complete this section if you don't want to.

Our commitment to you

- ✓ We will confirm with you that we have received your application.
- ✓ If we think we may be able to help you, we will invite you to an interview to discuss your application in more detail.
- ✓ We will keep you informed about how your application is progressing
- ✓ If we cannot offer you a place with our service we will let you know and give you the reasons for our decision.
- ✓ We will make sure we treat your application fairly and without discrimination.

Appeals process

If you are unhappy about any decision made in the application process, you can appeal to the service manager of the service you applied to. You can do this in writing, by telephone, or in person. Their details are on the front of this form

Monitoring

Spirit is committed to eliminating discrimination and promoting equality of opportunity. To ensure this we monitor the race, ethnicity, gender and disability of all applicants. Your information will be treated in the strictest confidence and used only as described above. It will not form part of the decision making process. You do not have to complete this section if you don't want to.

Gender	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Age	
Do you consider yourself to have a disability?		Yes <input type="checkbox"/> No <input type="checkbox"/>		
If yes, what sort of disability?	Sight disability <input type="checkbox"/>	Physical disability <input type="checkbox"/>		
	Hearing disability <input type="checkbox"/>	Learning disability <input type="checkbox"/>		
	Mental health disability <input type="checkbox"/>	Prefer not to say <input type="checkbox"/>		
Which group best describes your ethnicity?				
White	British <input type="checkbox"/>	Irish <input type="checkbox"/>	Other <input type="checkbox"/>	
Black or Black British	Caribbean <input type="checkbox"/>	African <input type="checkbox"/>	Other <input type="checkbox"/>	
Asian or Asian British	Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	
	Chinese <input type="checkbox"/>	Japanese <input type="checkbox"/>	Other <input type="checkbox"/>	
Mixed	White and black Caribbean <input type="checkbox"/>		White and black African <input type="checkbox"/>	
	White and Asian <input type="checkbox"/>		Other <input type="checkbox"/>	
Gypsies and travellers	Gypsy <input type="checkbox"/>	Romaine <input type="checkbox"/>	Irish traveller <input type="checkbox"/>	
	Other <input type="checkbox"/>			
Prefer not to say	<input type="checkbox"/>			
Sexuality	Heterosexual <input type="checkbox"/>	Homosexual <input type="checkbox"/>	Bisexual <input type="checkbox"/>	Transgender <input type="checkbox"/>
Religion				
Refuse to answer this section	<input type="checkbox"/>			