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| Please complete all parts of this form**By submitting this form, you grant permission for the relevant Purple team member to access this information and action any relevant processes.****For Purple Personal Assistants for DP holders: DP PA Referrals, please use this link** [**https://portal.purple-pay.co.uk/form/zvlym130xwapb5/**](https://portal.purple-pay.co.uk/form/zvlym130xwapb5/)**For Purple Independent Support brokerage: please complete this form and send to** **cfitzgerald@herts-dpss.co.uk****(until the link is available on our webpage)** [**https://herts-dpss.co.uk/direct-payments/**](https://herts-dpss.co.uk/direct-payments/) |

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| **Referrer Information:**  |
| Name: |
| Organisation / Team: |
| Phone: |
| Email: |
| Date of Referral: |
|  |
| **Social worker Information if different to referrer:** |
| Name:  |
| Organisation / Team: |
| Phone:  |
| Email:  |
|  |
| **Direct Payment holder / Self-funder User information:**  |
| Title: Mr [ ]  Mrs [ ]  Miss [ ]  Master [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Full Name: |
| Address: |
| Postcode: |
| Email: |
| Phone: |
| Mobile:  |
| DOB: Under 18 years [ ]   |
| Any communication needs:  |
|  |
| **Representative details (if unable to speak with Direct Payment holder / Self-funder directly)** |
| Title: Mr [ ]  Mrs [ ]  Miss [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Full Name: |
| Relationship to Direct Payment service user:  |
| Email: |
| Phone: |
|  |
| **Does the Direct Payment holder / Self-funder, currently have an identified paid care support / agency in place?** Yes [ ]  No [ ] Name of provider / agency: Telephone Number: Email Address: How long supported for:Any other information, such as need for change:  |
|  |
| **Has a care assessment been done / planned to be done:**  Yes [ ]  No [ ]  Planned [ ] Has a copy been sent with this referral: Yes [ ]  No [ ]  |
|  |
| **Direct Payment Information:** |
| Start date: |
| End date if fixed term:  |
| Amount per week:  |
| Hours per week: |
| Contribution from service user per week:  |
| Service User will be in control of the Direct Payment with a card: Yes [ ]  No [ ]  |
| **Please describe in as much detail what type of support / care plan needs the Direct Payment holder / Self-funder requires:***provide as much detail as possible alongside the care needs assessment:* |
| **Are there any identified risks or safeguarding concerns?** Yes [ ]  No [ ] *If Yes, please provide details:*   |
| **Anything else you would like to add:** |

**Client Monitoring Information – Please tick all that apply**

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| **White**British [ ]  Irish [ ] Gypsy/Traveller [ ] Any other White background [ ]  | **Asian or Asian British**Pakistani [ ]  Bangladeshi [ ] Indian [ ] Any other Asian background [ ]  |
| **Mixed Heritage**White and Black Caribbean [ ] White and Black African [ ] White and Asian [ ]  | **Black or Black British**Caribbean [ ]  African[ ] Any other Black background [ ]  |
| **Chinese or Other Ethnic Group**Chinese[ ] Other [ ]  | **Any other please specify:** |
| **Gender:**Male [ ]  Female[ ]  | **Sexual Orientation:**Heterosexual [ ]  Gay male [ ]  Lesbian[ ]  Bisexual [ ]  Other [ ]  |
| **Religion:**No religion [ ]  Christian [ ]  Buddhist [ ]  Muslim [ ]  Hindu [ ]  Jewish[ ]  Sikh [ ]  | **Client Groups:**Acquired brain injury [ ]  Mental Health - Older Peoples' [ ] Autistic Spectrum Disorder [ ]  Multiple disability [ ] Carers [ ]  Older Person [ ] Dependent child (under 18) [ ]  Physical Disabilities [ ]  Dementia [ ] Prisoner [ ]  Detained under Mental Health Act [ ]  Sensory disabilities – visual [ ] HIV/ Aids [ ]  Sensory disabilities – auditory [ ] Learning disabilities/difficulty [ ]  Sensory impairment - learning [ ] Long term illness/condition [ ]  Stroke [ ] Mental health condition [ ]  Substance misuse [ ]  |