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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**](mailto: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 |