**Client Details**

First Name: Surname:

Last Known

Address:

Gender: Nationality:

NINO : Mobile Tel:

DoB: Status:

**Partner Details**

First Name: Surname:

Last Known

Address:

Gender: Nationality:

NINO : Mobile Tel:

DoB: Status:

**Has either individual presented before?**

**YES NO**

**If YES please give details:**

|  |
| --- |
|  |

**Referred By:**

Name: Job Title:

Organisation: Phone:

**Clients Present Circumstances** (Reason for referral)**?**

**Does the client have a statutory entitlement to welfare benefits and/or housing services?**

**YES / NO**

**Does the client have identification? YES NO**

**If YES please take a photocopy**

**Other agencies currently involved and description of support delivered:**

**Additional Relevant Information**

**Has a Risk Assessment 6a been completed?**

**YES NO**

**If NO, reason for not completing:**

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| --- |
|  |

**Has the client(s) been offered accommodation?**

**YES NO**

**If NO reason for refusal**

|  |
| --- |
|  |

**Personal Information**

Provision of emergency overnight accommodation is at the discretion of Gateway. No individual has a right to access the accommodation. All individuals using the accommodation must provide sufficient personal information to allow their housing and benefit entitlement to be established. This information may be shared with other agencies in accordance with the Data Protection Act.

Staff Name Date

|  |  |
| --- | --- |
|  |  |

Client 1 Signature Date

|  |  |
| --- | --- |
|  |  |

Client 2 Signature Date

|  |  |
| --- | --- |
|  |  |

Referrals to Highland Crisis Accommodation may be made:

* By returning this form by email to [karen.patience@homelesstrust.org.uk](mailto:karen.patience@homelesstrust.org.uk)
* By telephone to 01463 718693 during normal office hours
* By telephone to 01463 233773 outside office hours and during the night
* By telephone to 07850 527522 outside office hours and during the night