

This Referral Form is for **St Bart's Homeless Services**. It should be completed with the applicants consent and, ideally, in the presence of. Please ensure all sections are completed, with the relevant supporting documents attached, before sending it to the Intake Team at intake@stbarts.org.au.

For any enquiries please email or call (08) 9323 5124.

Please note incomplete or illegible referrals will be returned, resulting in processing delays. Referrals will also be deemed incomplete until all of the applicable information has been received.

REFERRERS DETAILS

Referrers Name:

Date of Referral: / /

Organisation:

Position:

Email:

Phone:

ST BART'S HOMELESS SERVICES

Please ensure you read the eligibility criteria before referring to any of these services.

Which service are you applying for (*only 1 option can be selected*):

Transitional Supported Accommodation:

☐ Men's Service - Future Homes

☐ Women's Service

☐ Bart's Plus - Family Service

(Please note we only accept referrals for our Family Service when we have a vacancy)

APPLICANTS DETAILS

First Name:

Surname:

Preferred Name:

Date of Birth: / /

Preferred Pronouns:

Full Address:

Postcode:

Email:

Phone:

Gender: ☐ Male ☐ Female ☐ Agender ☐ Gender Diverse
☐ Non-binary ☐ Transgender Male ☐ Transgender Female ☐ Other:

Do you identify as LGBTIQA+: ☐ Yes ☐ No ☐ Unsure ☐ Prefer not to say

Aboriginal: ☐ Yes ☐ No ☐ Prefer not to say **Torres Strait Islander:** ☐ Yes ☐ No ☐ Prefer not to say

Culturally and Linguistically Diverse: ☐ Yes ☐ No ☐ Prefer not to say

Main language spoken: ☐ English ☐ Other: _____ **Country of Birth:**

Interpreter required: ☐ Yes ☐ No **English Proficiency:** **Visa status:**

Marital Status: Never Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

IF APPLYING FOR BART'S PLUS FAMILY SERVICE

(please answer the below questions)

Are you applying as a couple with children? ☐ Yes ☐ No I'm a single applicant with children

If yes, provide full name of the other applicant _____

If another adult is listed, they must also complete a separate referral and be sent together

Who else will be living with you:

Full name: Date of Birth: Gender: Relationship:

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HEALTH

Do they have any health issues: ☐ Yes ☐ No Details:

SUPPORT NEEDS

Do they require any support: ☐ Yes ☐ No Details:

SCHOOL

Are the children attending school: ☐ Yes ☐ No More information:

LEGAL

Are there custody issues: ☐ Yes ☐ No Do you have primary custody: ☐ Yes ☐ No

Are there any current Family Violent Restraining orders in place: ☐ Yes ☐ No

Is the Department for Child Protection and Family Support [DCPFS] involved: ☐ Yes ☐ No

More information:

FINANCE

Source of income: ☐ Age Pension ☐ Youth Allowance ☐ Disability Support Pension

☐ New Start Allowance / JobSeeker ☐ Paid Work* ☐ Parenting Payment Other: _____

**if in paid work we will need 3 months of payslips in order to calculate your rent*

Centrelink Customer Reference Number (CRN):

Expiry:

Medicare Number:

Expiry:

Do you hold a Department of Veterans' Affairs [DVA] Health Card: ☐ Yes ☐ No

HOUSING

Have you stayed at St Bart's before: ☐ Yes ☐ No If yes, when:

Housing History:

Current living situation: ☐ Privately owned ☐ With friends ☐ Hospital ☐ Rental
☐ Supported ☐ Homeless ☐ With carer / family ☐ Hostel ☐ Refuge ☐ Other: _____

Are you on the housing waitlist: ☐ Yes ☐ No **Are you priority listed:** ☐ Yes ☐ No

If known, date of when application was submitted:

Are you on the By-Name's list: ☐ Yes ☐ No

CONTACTS

Name of Next of Kin or Nominated Support Person:

Relationship:

Email:

Phone:

Do you have a Case Manager: ☐ Yes ☐ No

Name:

Email:

Phone:

Do you have a Guardian: ☐ Yes ☐ No

Name:

Email:

Phone:

Do you have a Public Trustee: ☐ Yes ☐ No

Name:

Email:

Phone:

Do you have a DCPFS Case Worker: ☐ Yes ☐ No

Name:

Email:

Branch:

Phone:

Do you have a Community Corrections Officer: Yes ☐ No

Name:

Email:

Location:

Phone:

Other Support Person / Service (e.g. NDIS, Family Support Services, School, Silverchain etc.):

Name:

Email:

Phone:

DISABILITY

Do you have a Disability, Please specify

☐ N/A

Do you have a current NDIS Plan: ☐ Yes ☐ No *If yes, please include a copy of the plan*

Do you have any current support from a Disability service (e.g. Silverchain etc.): ☐ Yes ☐ No

Details:

PHYSICAL HEALTH

Any physical health conditions: ☐ Yes ☐ No e.g heart complaint, hepatitis, HIV, recent fall, ABI, pregnant

Details:

MENTAL HEALTH

If you have a Mental Health diagnosis, please specify:

☐ N/A

Are you under the care of a Community Mental Health Service: ☐ Yes ☐ No ☐ Yes, once discharged

If applicable please provide a copy of the Client Management Plan, Risk Assessment Management Plan & PSOLIS alerts

If you ticked yes, please specify which area / team:

Are you on a Community Treatment Order [CTO]: ☐ Yes ☐ No (Please provide CTO)

Any hospital admissions in the last 12 months: ☐ Yes ☐ No (Please provide Discharge Summary)

If yes, provide details of admission (reason, dates etc):

DRUG AND ALCOHOL USE

Do you have a history or are you currently using drugs and/or alcohol:

☐ Yes ☐ No

If yes, please provide details of drug(s) of concern, frequency, amount, history of use:

Are there any associated risks, behaviours or problems: (e.g. Aggression, Hepatitis, injecting, overdose): ☐ Yes ☐ No

If yes, please provide details:

Are you currently accessing support around your substance or alcohol use:

☐ Yes ☐ No

If yes, please provide details:

LEGAL ISSUES

Do you have any past or current legal issues:

☐ Yes ☐ No

(e.g. Community orders / pending court dates / prison history):

If yes please provide a copy of forensic history including any current legal issues (e.g. orders, upcoming court dates)

Provide details:

If being referred from prison, please answer these questions:

Prison location:

Time length in prison:

Full sentence date:

Convictions (include above)

Are you applying for Parole: ☐ Yes ☐ No

If yes, Parole date:

Have you been assigned a Community Corrections Officer:

Yes ☐ No

SUPPORT NEEDS

Are there any particular tasks you find challenging and require additional support with:

(e.g cooking, cleaning, personal care, medication, parenting support etc)

ADDITIONAL

Is there any additional information we need to know:

SIGNED CONSENT

I acknowledge the information provided is correct and true. I agree that St Bart's may contact my health/community services or my contacts provided to gather additional information to assist with my referral, if needed.

I consent to my referral being submitted for consideration of the selected St Bart's Homeless Service.

Application name:

Date: / /

Signature:

*If the applicant has a state appointed Guardian, they must additionally sign :
(referrals will not be processed until signed)*

Guardian name:

Date: / /

Signature:

We will be in touch once your referral has been received and reviewed by our Intake Team!