TEAMhealth
TOP END ASSOCIATION FOR MENTAL HEALTH INC

Referral Form – Community Housing Service

TEAMhealth Community Housing Service (CHS)
CHS is a transitional housing option which operates in Darwin and Palmerston; for individuals who have a diagnosed mental illness and are aged between 18 – 64 years old; requiring non-crisis accommodation support, while they establish stable housing and seek to obtain more permanent accommodation either within Territory Housing or the private rental sector.

Accommodation options include single, share units and houses. Accommodation available is limited and therefore not all of these options may be available upon the time of your application to Community Housing Service.

To be eligible for referral to the program, the referee must meet the following conditions;

- Be 18 – 64 years old
- Have a diagnosed Mental Illness
- Be waitlisted for a Territory Housing and maintain this status for the duration of their placement with CHS
- Be engage with a TEAMhealth Outreach Program such as; TEAMhealth Recovery Assistance Program for a minimum of 4 weeks
- Be engaged with and continue to remain engaged with Top End Mental Health Services Case Manager or GP

Participant Details:

Name:	**DOB:**	**Gender:** ☐ Male ☐ Female ☐ Other
Address:	**Telephone:** **Mobile:** **Email address:**	
Are you: Aboriginal: ☐ Yes ☐ No Torres Strait Origin: ☐ Yes ☐ No CALD: ☐ Yes ☐ No	**Country born:** **Primary language spoken:** **Interpreter required:** ☐ Yes ☐ No	

Are you experiencing mental illness? ☐ No ☐ Yes
If yes please provide details:

Are you on any medications in regards to your mental health? ☐ No ☐ Yes
If yes, do you manage these independently ☐ No ☐ Yes

Do you require support? ☐ No ☐ Yes

Do you have a GP and or Top End Mental Health Services Case Manager that you are actively engaging with? ☐ No ☐ Yes
If yes please provide details:

Are you currently receiving a Centrelink benefit or other income ☐ No ☐ Yes
If yes please provide a copy of your income statement
Income received per fortnight:
Centrelink Reference Number (CRN) number:
Are you currently receiving any other income? ☐ No ☐ Yes
If yes please provide details:

Are you currently on the NT Housing waitlist ☐ No ☐ Yes
If yes please provide details:

Are you willing to be supported to be placed on the Territory Housing Priority Housing waitlist ☐ No ☐ Yes

Do you have money saved for bond? ☐ No ☐ Yes
Will you require assistance with bond? ☐ No ☐ Yes
If yes please provide details:

Have you had any difficulties paying rent in the past? ☐ No ☐ Yes
How have you managed this?

Do you have any outstanding debt that may affect your ability to pay rent? ☐ No ☐ Yes
If yes please provide details:

What is your current Housing situation:
☐ Homeless ☐ Supported Accommodation Assistance Program (SAAP) agency ☐ Hostel
☐ Private rental ☐ Territory Housing ☐ Institution or Correctional Facility ☐ Other *(please specify)*
Please provide details:

Indicate Tenancy History for last 12 months: ☐ With Family ☐ Govt. Housing ☐ Private Rental ☐ Hostel
☐ Couch Surfing ☐ Homeless ☐ Emergency Shelter ☐ Prison ☐ Hospital ☐ Other
Please provide details:

Do you have any outstanding debt or are you on a payment plan?
☐ Centrelink Debt: Amount: __________ Outstanding: __________ Payments: _______________
☐ Credit Card/ Personal Loan: Amount: __________ Outstanding: __________ Payments: _______________
☐ Power/Water/Telephone: Amount: __________ Outstanding: __________ Payments: _______________
☐ Housing: Amount: __________ Outstanding: __________ Payments: _______________
☐ Other: ____

Type of Accommodation Required:
☐ Single / Share ☐ Family - *if family accommodation required, please complete the following:*
Number of family members requiring accommodation.
Details of other family members:
1. Full name: DOB: / / AGE: ________
2. Full name: DOB: / / AGE: ________
3. Full name: DOB: / / AGE: ________
4. Full name: DOB: / / AGE: _______

On what basis will the children reside with you? ☐ Full Time ☐ Part Time ☐ Visitation
What does this look like?

Are any children over 16? ☐ No ☐ Yes
Do they have access to their own income? ☐ No ☐ Yes
If yes please provide details:

Are you involved with other support services
If yes, what agencies are you involved with?

Please provide as much information as possible to assist with the assessment process.
Please include additional information if required and attach separate document/s.
N.B. This checklist must be completed for TEAMhealth to accept the referral (please tick all relevant boxes).

Drug and/or alcohol: ☐ History, current use ☐ Impact current use has on lifestyle ☐ Treatment interventions ☐ Engaged with AOD services	Additional documentation attached ☐
Physical illness: ☐ Epilepsy ☐ Asthma ☐ Heart Disease ☐ Diabetes ☐ Allergies ☐ Mobility issues ☐ Infectious diseases such as Hepatitis ☐ Nutrition or vitamin deficiencies ☐ Other *(please specify)*	Additional documentation attached ☐
Legal issues: ☐ Pending criminal proceedings ☐ Relevant criminal history ☐ Guardian or Trustee involvement ☐ Department of Children and Families (DCF) involvement ☐ Other *(please specify)*	Additional documentation attached ☐
Risk issues: ☐ History of aggressive behaviour ☐ Previous risk to self and others, including staff ☐ Other *(please specify)*	Additional documentation attached ☐

Any other considerations to support this referral:

Person referring or referral agent details

☐ I confirm that I have consented for this referral to occur.
☐ I confirm that I have consented to the sharing of information between TEAMhealth and the referring agency for referral purposes.

(please note that a referral cannot be accepted without a person's consent)

Name:	**Signature:**	**Date:**
Person referring: **Organisation:** **Telephone:** **Email address:**	**Signature:**	**Date:**

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