

Ready to Rent Referral Form



TeamHEALTH actively promotes and supports an inclusive and diverse culture. We welcome all people, regardless of age, gender, race, ability, sexual orientation, faith, religion and other identities represented in our community.

In the Ready to Rent program, TeamHEALTH secures head tenancies in the private market, then makes these properties available as sub-tenancies to people who are at risk of homelessness.

This transitional housing program provides housing for 6-12 months for people who are aiming to re-enter the social housing or private rental market but are having trouble securing a tenancy. Housing is offered at 75% of Market Rent.

Please note that the **bolded** questions marked with an asterisk (*) are required for referral to be accepted.

Participant Details

*Participant's Name:	_____	Preferred Name:	_____
*Date of Birth:	_____	*Country of Birth:	_____
*Year of Arrival to Australia:	_____		
*Gender Identity:	☐ Woman ☐ Man ☐ Non-binary		
	☐ Different term – please specify: _____		
Pronouns (optional):	_____		
Address:	_____		
Email Address:	_____	Phone Number:	_____
*Preferred language:	_____		
<i>(The language the participant feels most comfortable using)</i>			
Interpreter needed?	☐ No ☐ Yes	If yes, what language?	_____
Any other language or communication supports needed? ☐ No ☐ Yes			
If yes, please describe: _____			
<i>(For example: Auslan, large print, a communication device, or a support person)</i>			
Is the participant of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander			
<i>(Select both Yes options if this applies to you)</i>			
Cultural identity (optional): _____			
<i>(How would you describe your cultural identity or background? For example, your heritage, community or cultural group?)</i>			
*Culturally & Linguistically Diverse:	☐ No ☐ Yes		
Public Guardian in place?	☐ No ☐ Yes	Name & Phone Number:	_____
Carer in place?	☐ No ☐ Yes	Name & Phone Number:	_____
Case Manager in place?	☐ No ☐ Yes	Name & Phone Number:	_____

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Participant Details

Preferred way of communication? ☐ Call ☐ Text ☐ Email ☐ Other

***Has the participant contacted any other homelessness service/agency today before referring to Ready to Rent?**

☐ No ☐ Yes

If yes, please provide details:

***How urgently is access to this support expected, if approved?**

- | | |
|--|---|
| ☐ Within 24 hours | ☐ In 7-14 days |
| ☐ Between 24 and 48 hours | ☐ In more than 2 weeks |
| ☐ In 3-4 days | ☐ Don't know |
| ☐ In 5-6 days | |

Reasons:

***Accessed TeamHEALTH supports previously?** ☐ No ☐ Yes List Services and Dates:

***Current Living Situation:**

- | | |
|--|---|
| ☐ Homeless (rough sleeping/couch surfing) | ☐ Low-income with housing insecurity |
| ☐ At risk of homelessness | ☐ Other: |

If other, please provide more information:

On Department of Housing Waitlist: ☐ No ☐ Yes ☐ Yes, on the Priority Waitlist

If on the Department of Housing Waitlist, since when?

Referral Details

Person Referring:

Relationship to Participant:

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Referral Details

Phone Number: _____

Email: _____

Referrer's Signature: _____ Date: _____

Consent

TeamHEALTH is collecting this information to set up and provide your support. We'll store it securely and only share it where it's needed to arrange or deliver that support. You can ask to see or correct your information, or withdraw your consent, at any time. This won't affect the support you receive.

☐ I consent to this referral

Your information is handled in line with the *Privacy Act 1988 (Commonwealth)*, the *Australian Privacy Principles*, and the *NT Information Act*.

Signature of Participant

Signature of Public Guardian (if applicable)

Date

In the absence of written consent, verbal consent was gained ☐ No ☐ Yes

Essential Criteria

*Service Region:

Ready to Rent is available for eligible individuals and families in Greater Darwin Region.

- ☐ Darwin City
☐ Darwin Suburbs
☐ Palmerston

*Service User Group (tick all that apply):

- ☐ Aged 18 years or over (Adult Occupant/Main Applicant)
☐ Currently experiencing homelessness or at risk of homelessness

Supporting Documentation

***For us to assess your eligibility, please provide as many of the below as possible:**

Centrelink or Income Statement: ☐ Yes ☐ No CRN: _____

Proof of Income (payslip, ATO notice): ☐ No ☐ Yes

Rental history evidence (rental ledger, rental invoices etc.): ☐ No ☐ Yes

Other hardship evidence (debts, support letter, eviction notice): ☐ No ☐ Yes

Reasons for the inability to access the private rental market independently (tick all that applies):

Supporting Documentation

- | | |
|--|--|
| ☐ Low income | ☐ Disability |
| ☐ Unemployment | ☐ AOD |
| ☐ Mental Health | ☐ Previous Eviction |
| ☐ Physical Health | ☐ Poor rental history |
| ☐ Other _____ | |

Briefly describe the reasons, to help us understand the situation and plan appropriate supports:

Clear goal to eventually enter the private rental market independently: ☐ No ☐ Yes ☐ Not Sure

Expected entry date: _____

Able to contribute towards rent and household costs as agreed under the program: ☐ No ☐ Yes ☐ Not Sure

Housing & Tenancy Criteria

- ☐ No viable alternative safe housing options available
- ☐ Able to live independently with appropriate supports in place
- ☐ Willing to participate in a tenancy establishment plan and adhere to occupancy agreement conditions
- ☐ Not currently subject to tenancy bans or legal orders that prevent renting (unless risk can be mitigated)

Wellbeing & Support Criteria

- ☐ Open to regular case management and recovery-focused support
- ☐ Willing to develop and work towards Individual Recovery Plan and Tenancy Plan
- ☐ Prepared to participate in life skills development (e.g., budgeting, household maintenance)

Rental References

Please provide 2 rental references to support the application.

This can be your previous landlord or property manager. If you lived with a family member or friend who was the named tenant or owner, they can provide a reference.

Note: This is not a mandatory requirement but will strengthen your application.

Referee 1 Name: _____

Referee Relationship to Applicant: _____

Phone Number: _____

Email: _____

Rental References

Referee 2 Name: _____

Referee Relationship to Applicant: _____

Phone Number: _____

Email: _____

Risk Assessment (Referrer to complete)

TeamHEALTH requires a brief risk assessment to ensure that we understand how to keep our staff, participants and community safe. If you are completing a self-referral and need assistance filling out a risk assessment, please call on us on the number below.

Participant risk factors <i>If selecting yes to any of the below, please expand on or attach relevant information/documentation.</i>	Yes	No
History of suicide attempt/s or current suicide ideation (e.g. chronic, recent)	☐	☐
Please provide further details:		
History of self-harm (e.g. chronic, recent)	☐	☐
Please provide further details:		
Recent traumatic life event (e.g. assault, bereavement, legal concerns, family violence, homelessness etc.)	☐	☐
Please provide further details:		
Historical or current drugs or alcohol use	☐	☐
If yes, please provide details of substances and any history of rehab or AOD counselling:		
Forensic history (including DVO, custodial orders, recent incarceration, upcoming legal matters, parole or bail conditions)	☐	☐

Risk Assessment (Referrer to complete)		
Please provide further details:		
Recent incident involving aggression/violence/weapon use or possession	☐	☐
Please provide further details:		
Expressing intent to harm others/preoccupation/hallucinations with violent or paranoid themes/ideas	☐	☐
Please provide further details:		
Inappropriate sexual behaviour	☐	☐
Please list serious events or presenting behaviours:		
Reduced ability to self-control /difficulties with emotional regulation etc.	☐	☐
Please provide further details:		
Known prejudices – ethnic, religions, (including prejudices that emerge as part of psychosis)	☐	☐
Please provide further details:		
Vulnerabilities (financial abuse, trauma history, relational/sexual)	☐	☐
Please provide further details:		

Protective factors (e.g. friends, family, professional relationships, culture, faith, hobbies, study, employment etc.):

Recommendations to support the safety and comfort of the person in our service (e.g. safety plans, coping strategies, skills or strengths)

Completing this Form

- Please call TeamHEALTH on **1300 780 081** if you need any assistance completing this form.
- Send the completed form to: teamhealth@teamhealth.asn.au.
- TeamHEALTH will contact the participant or Public Guardian within three working days of receiving this form.

Thank you for your referral!