* The Family Housing Program provides supported, medium term transitional accommodation for a period of up to twelve months.
* The program cannot offer crisis accommodation.

**Referral Process:**

* **Check that your client meets the following criteria:**
	+ Homeless or at imminent risk of homelessness.
	+ Two or more children under the age of sixteen in their full-time care and are receiving Centrelink payments for the children.
	+ A support need relating to maintaining and sustaining a tenancy and willingness to actively engage in a support plan, including weekly home visits.
	+ On the priority waitlist with the Department of Communities Housing (DoCH).
	+ Be eligible for a DoCH bond loan or be able to pay private bond.
* If your client meets the criteria above, please complete this referral form (which can be filled out electronically) with as much detail as possible, and attach required documentation, as listed below.
* Send the referral and supporting documents via e-mail to the Housing & Administration Service Support Officer (SSO) at: housing@anglicarewa.org.au
* Receipt of the referral will be acknowledged by email within seven (7) working days.
* Please note that the program does operate a waitlist, and, during periods of high demand, the waitlist may be closed to new applicants.
* The SSO will provide feedback to the referee as to the outcome of the referral.

**Please check you have attached the following:**

|  |
| --- |
|[ ]  Centrelink Income Statement |
|[ ]  Priority waitlisting confirmation letter from the DoCH |
|[ ]  Bond loan approval letter from the DoCH |
|[ ]  Legal orders: VRO, Family Court orders etc. |
|[ ]  Risk Assessment (CRAMRF) |
|[ ]  CALD clients: Permanent Residency & Visa status information |

|  |
| --- |
| **Referring Agency Details** |
| **Date** |       /       /       | **Agency Worker** |       |
| **Name of Agency** |       |
| **Contact Details** | **Phone** |       |
| **Email** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Client’s Name** |       | **DOB** |       /       /       |
| **Alias, Known as or Preferred Name** |       |
| **Centrelink Customer Reference Number (CRN)** |       |
| **Gender**  |       | **Pronoun** |       |
| **Address** |       | **Post Code** |       |
| **Mobile** |       | **Email** |       |
| **Nationality** |       | **Country of Birth** |       |
| **Cultural Identity (Aboriginal, Torres Strait Islander, Māori etc.)** |       |  |
| **Language spoken, other than English.****Interpreter required?** [ ]  Yes [ ]  No |       |
| **Visa Type**  |       | **Year of Arrival** |        |
| **Do you have a legal guardian or public trustee?**  | [ ]  Yes [ ]  No |
| **Details:** |       |

|  |
| --- |
| **Accompanying Children or Household Members** |
| **Name** | **Age** | **DOB** | **Gender** | **Relationship to Applicant** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

|  |
| --- |
| **Which Housing Authority Zone is the Client priority waitlisted in?** |
|       |

|  |
| --- |
| **Which Area/Zone does the Client wish to live in (if different to the above)?** |
|       |

|  |
| --- |
| **Any Area/Zones the Client needs to avoid and why?** |
|       |

|  |
| --- |
| **Reason for Referral, Including Support Need** |
|       |

|  |
| --- |
| **What is the Current Living Situation?** |
|       |

|  |
| --- |
| **Presenting Issues inc. (drug and alcohol, legal issues, FDV, health, financial, family, etc.)** |
|       |

|  |
| --- |
| **Is the client Working with any other Services? If so, please list** |
|       |

|  |
| --- |
| **Client’s expectations from the Family Housing Program** |
|       |

|  |
| --- |
| **Brief History / Client’s Motivation** |
|       |

|  |
| --- |
| **Offending History or Any Known Risk Factors for Working with the Client** |
|       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency Worker’s Signature** |  | **Date** |       /       /       |
| **Clients Signature** |  | **Date**  |       /       /       |

|  |
| --- |
| **Office Use Only** |
| **Date Contact Made with Client** |       /       /

|  |  |  |
| --- | --- | --- |
| **Referral Accepted** | [ ]  Yes | [ ]  No |

 |
| **Reason for Non-Acceptance** |       |
| **Client Referred to** |       |

Thank you for your referral