**SWAN Community Advocacy Referral Form East Sussex Residents**

**Adults**

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| **SWAN supports clients in need of community advocacy who meet the eligibility criteria within East Sussex.**  We accept self-referrals or referrals made from third parties | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Are you asking for an advocate for yourself?** | | | | | | | | | | | | | | | | | | | | | |  | | Yes | | | | | |  | | | | | | | No |
| **If you are asking for an advocate for someone else, have they given consent?** | | | | | | | | | | | | | | | | | | | | | |  | | Yes | | | | | |  | | | | | | | No |
| **May we contact the client directly?** | | | | | | | | | | | | | | | | | | | |  | | | | Yes | | | | | | | |  | | | | | No |
| **If not, then whom should we contact?** | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| **Client Details**  *(the client is the adult needing an advocate)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name:** | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Preferred Name:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Pronouns:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *(if known)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Address at Point of Referral:** *(if hospital, please include ward name)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Postcode:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Telephone No.** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Email Address:** | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Home Address:** *(if different)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Postcode:** | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Birth:** | | | | | | | DD/MM/YYYY | | | | | | | | | | | **Sexual Orientation:** | | | | | | | | | | | Sexual Orientation | | | | | | | | |
| **Ethnicity:** | | | | Ethnicity | | | | | | | | **Religion:** | | | | | Religion | | | | | | | | | **Gender:** | | | | | | | | | Gender | | |
| **Is their gender the same as assigned at birth?** | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | No | | | | | | | Prefer not to say | | | |
| **Do they have any disabilities:** *(please tick all that apply)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Chronic or long-term condition | | | | | | | | | | | |  | | | Learning disability | | | | | | | | | | | |  | | | | | Mental illness | | | | |
|  | Chronic or long-term pain | | | | | | | | | | | |  | | | Memory | | | | | | | | | | | |  | | | | | Mobility | | | | |
|  | Hearing | | | | | | | | | | | |  | | | Neurodivergent | | | | | | | | | | | |  | | | | | Neurological condition | | | | |
|  | Speech or language | | | | | | | | | | | |  | | | Stamina, breathing or fatigue | | | | | | | | | | | |  | | | | | Vision | | | | |
|  | Other | | | | | | | | | | | |  | | | Prefer not to say | | | | | | | | | | | | | | | | | | | | | |
| **If other, please specify:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Is the client a Carer?** | | | | | | | | | | | | | | |  | | | | Yes | | | |  | | No | | | | | |  | | | | | Prefer not to say | |
| **Has the client ever served in the Armed Forces?** | | | | | | | | | | | | | | |  | | | | Yes | | | |  | | No | | | | | |  | | | | | Prefer not to say | |
| **Any communication needs?** | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **This service is available to residents of East Sussex who are funded by East Sussex County Council and:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Aged 65 or over | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Between 18 and 65 with physical disabilities | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Between 18 and 65 with sensory impairments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Over the age of 18 with a learning disability | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Over the age of 18 with mental health issues | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | A carer of someone eligible under the above categories | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **Advocacy Need:** | |
|  | Support to request or to attend assessment and review processes for care packages and financial assessments for care. |
|  | Challenging decisions for Adult Social Care services, including personal budgets, client  contributions and placement decisions. |
|  | To make a complaint about Adult Social Care. |
|  | For support around direct payment issues |
|  | Need support through safeguarding or best interest process |
|  | Need to raise safeguarding |
|  | Support around the financial appeal process |
|  | Advocacy support with Occupational Therapy issues |
|  | Complaints to the Local Government and Social Care Ombudsman |
|  | Accessing services re mental health care and treatment |
|  | Supporting Carers to apply for Carers assessments |

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| **Any vulnerabilities we should consider when visiting, contacting or arranging to meet with them?**  (e.g. do they have difficulty in communicating verbally/in writing, mental health issues, substance use etc.) | | | | | | | |
|  | | | | | | | |
| **Are there any risks that we should be aware of when visiting or arranging to meet the client?** | | | | | | | |
|  | | | | | | | |
| **Any key information and/or key dates:** | | | | | | | |
|  | | | | | | | |
| **Referrer Details**  *(if other than the client)* | | | | | | | |
| **Full Name:** | |  | **Job Title:** | |  | | |
| **Address**: | | | **Organisation/Agency:** | | | |  |
| **Relationship to client:** | | |  | |
| **Postcode:** | |  | **Tel:** |  | | | |
| **Email:** |  | | | | | | |
| **In making this referral, I declare that:**   * **I wish to request advocacy support from South West Advocacy Network (SWAN).** * **I understand that client information supplied on this form will be stored safely on SWAN’s system.** * **I confirm that I have consent from the client to make the referral or I have the authority to make the referral for the client.**   By requesting advocacy support, you give consent to SWAN sharing information where necessary for the purpose of providing this service. All data held by SWAN is held in accordance with the current UK General Data Protection Regulations legislation. | | | | | | | |
| **What happens next?**  **Email this form to** [**eastsussex@swanadvocacy.org.uk**](mailto:eastsussex@swanadvocacy.org.uk)  **Acknowledgment** – You will receive confirmation of receipt of your referral within a few hours, this will contain a case number. If you have not received this by the next working day, please contact us.  **Review** – We will check the referral includes all the information that we require.  **Clarify** – If there is any missing information, issues about eligibility, etc we will contact you and request this.  **Allocate** – As soon as we have all of the information we need, we will allocate and provide the contact details of who has been assigned, and you can liaise with them directly. | | | | | | | |