**BOLTON COUNCIL BROKERAGE REFERRAL FORM**

This form must be completed in **FULL.** As agreed with Bolton Council, Disability Positive will reject the referral if **all** information is not provided.

**Client Details:**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | First name |  |
| Surname |  | DOB |  |
| Address |  | Postcode |  |
| Liquid logic number  |  |
| Telephone |  | Ethnic Origin |  |
|  Mobile |  | Email address |  |
|  | Other things we need to know when contacting this person i.e. preferred method of communication? |
|  | **Risk / Access Issues:**Specify any known risks including reason why a face-to-face visit is essential (if applicable): |

**Who to contact in the first instance, if not the client:**

|  |  |  |  |
| --- | --- | --- | --- |
| Title |  | First Name |  |
| Surname |  | Relationship to service user and/or representative: |  |
| Address: |  | Postcode: |  |
| Telephone: |  | Power of attorney: |  |
| Mobile: |  | Email address: |  |

**Details of the Person making the referral:**

|  |  |
| --- | --- |
| Name of Referrer: |  |
| Tel: |  |
| Email: |  |
| Referral Source(Team): |  |
| Client Group to fund support (PD, LD, MH, ELD, CHILD) |  |
| Date Direct Payment support to start from: |  |

**Please confirm below which option for support is being requested:**

|  |  |
| --- | --- |
| **Nature of referral** |  |
| * Direct Payments set up to employ a PA - (please state if a new support plan is required)
 |  |
| * Direct Payments set up to engage a care provider (please state if a new support plan is required)
 |  |
| * Long-term support and advice around Direct Payments for current DP user
 |  |
| * Auto-enrolment support and advice
 |  |
| * Payroll set up
 |  |
| * Supported banking set up
 |  |

**Budget Information**

|  |  |
| --- | --- |
| How is the delivered – PA or Agency? |  |
| Number of Hours |  |
| Agency Name & Rate? (If known) |  |
| Is double-handed care required at any time? |  |
| Direct Payment Start Date |  |
| What date was the Financial Assessment completed? |  |
| What does the client have to contribute towards Direct Payments? (This is the outcome of the Financial Assessment)  |  |
| Is the person currently in receipt of services? |  |
| Is any of the budget to be spent on ‘In-house services’ or Day Services? If so, how much, days required?  |  |
| Has a copy of the assessment been included with this referral? |  |
| Has a copy of the support plan been included with this referral? |  |
| Has the person been made aware of the referral to Disability Positive? |  |

**Submit referral:**

* **Please include a copy of the My Needs Assessment if a new Direct Payment and a new support plan is required.**
* **Please include a copy of the Support Plan if Direct Payment support is required.**

The form is now complete and ready to be emailed to ‘Disability Positive’.

Please put **“Bolton Referral”** in the subject line of your email.

Please email cmicb-cheshire.boltonbrokerage@nhs.net

Your referral will be acknowledged within 2 working days by a team member.

For more details you can contact Disability Positive on:

**Tel: 03301641040**

­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For office use only**

|  |  |
| --- | --- |
| Disability Positive Adviser |  |
| Checklist & Agreement |  |
| Suitable Person Form |  |
| BACS Mandate |  |