Age UK Oldham Information, Advice and Support Services assists people in claiming **pension age benefits, disability benefits and carers allowance**. All referrals will receive an initial telephone call within 2 working days of receiving referral. To make a referral to the service please fully complete this form and return to **laura.maguire@ageukoldham.org.uk** or post to: **Age UK Oldham, 10 Church Lane, Oldham OL1 3AN.**

|  |  |  |
| --- | --- | --- |
|  |  | **20** |

**Referral Date:**

|  |
| --- |
| **Service user details** |
| **Name:**  | **Telephone:**  | **Date of Birth:**  |
| **Address:**  |
|  | **Postcode:**  |
| **Has the service user given consent for a referral to be made?** | Yes [ ]  No [ ]  |
| **Is the service user receiving any benefits at the current time? This includes means / non means tested.** *(Please give brief details)* |

 **Is the service user a carer?** Yes [ ]  No [ ]  Unknown [ ]

 **Does the service user live alone?**  Yes [ ]  No [ ]  Unknown [ ]

 **Does the service user struggle with daily living tasks?** Yes [ ]  No [ ]  Unknown [ ]

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| --- |
| **Is there any other representative you would like us to contact in relation to the referral?** |
| **Name:** | **Tel:** | **Relation:** |

|  |
| --- |
| **Type of help needed, if known.** |

|  |  |
| --- | --- |
|[ ]  **Attendance Allowance** | [ ]  Home Visit [ ]  Office Visit |
|[ ]  **Attendance Allowance and Benefit Check** | [ ]  Home Visit [ ]  Office Visit |
|[ ]  **Attendance Allowance and Blue Badge** | [ ]  Home Visit [ ]  Office Visit |
|[ ]  **Attendance Allowance and Council Tax Reduction / Housing Benefit (Over State Pension age)** | [ ]  Home Visit [ ]  Office Visit |
|[ ]  **Attendance Allowance and Pension Credit** | [ ]  Home Visit [ ]  Office Visit |
|[ ]  **Benefit Check** | [ ]  Telephone Appointment [ ]  Office Visit |
|[ ]  **Blue Badge** | [ ]  Office Visit |
|[ ]  **Carers Allowance** | [ ]  Telephone Appointment [ ]  Office Visit |
|[ ]  **Council Tax Reduction / Housing Benefit****(Over State Pension age)** | [ ]  Office Visit |
|[ ]  **Help with health costs (HC1)** | [ ]  Office Visit |
|[ ]  **Pension Credit** | [ ]  Office Visit |

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| **Please tick if your client has any of the following** |

|  |  |
| --- | --- |
|[ ]  Hearing impairment |[ ]   Mobility / physical problems |
|[ ]  Speech impairment |[ ]   Other (Please specify):  |
|[ ]  Cognitive impairment  |  |  |

**Risk Assessment**

Please answer the following questions fully.

**Is the service user at risk of, or experiencing:**

**Self-neglect?**  Yes [ ]  No [ ]  Unknown [ ]

**Intentional self-harm?** Yes [ ]  No [ ]  Unknown [ ]

**Abuse from others?** Yes [ ]  No [ ]  Unknown [ ]

**Violence / aggression?** Yes [ ]  No [ ]  Unknown [ ]

**Environmental hazards?** Yes [ ]  No [ ]  Unknown [ ]

**Any other risk factors?** If yes, please explain in further comments.

|  |
| --- |
| **Further Comments / Access to property:** |
|  |

|  |
| --- |
| **Any other relevant information:** |
|  |

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| --- |
| **Referrer details** |
| **Name:**  | **Telephone:**  |
| **Organisation:**  | **Email:**  |

**Office Use Only**

**Applications**

Date received \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date processed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Processed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Contact**

Date client contacted \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Contacted by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appointment made: Yes / No Date of appointment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Completed**

Confirmed as completed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_