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 **jessica.brooks@ageukoldham.org.uk** or post to:

**Age UK Oldham, 10 Church Lane, Oldham OL1 3AN.**

|  |  |  |
| --- | --- | --- |
|  |  | **2019** |

**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

|  |  |  |
| --- | --- | --- |
| **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 |

|  |
| --- |
| **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:** |
|  |

|  |  |
| --- | --- |
| **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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_