**York Carers Centre Referral Form**



York Carers Centre supports carers who live in York or care for someone who lives in York. Please complete page1 - 2 for basic registration, 1- 4 if you would like a Carers Assessment of Need. When you register with us, you will be sent an Information Pack which explains about our services.

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| **Information about you the carer:** | |
| **Name:**  **Address:**  **Telephone:**  **Mobile:**  **Email:**  **Date of Birth:**  **Gender:**  **GP Name and Address:**  **Are you in:**  Full time employment  Part time employment Voluntary work  Other - please give details: | |
| **Information about the person you care for:**  **Name:**  **Date of Birth:**  **What is your relationship to the person you care for?**  Spouse or Partner Friend Child  Parent Other Relative  Neighbour  **Do they live at the same address as you?** Yes  No  Address if different to yours: | |
| **What is the primary reason for their needing care or support from you?**  Physical- Long Term Health Condition  Frail Elderly  Learning, Developmental or Intellectual  Disability  Sensory Impairment Visual  Dual sensory impairment  Other:  Neurological- Long Term Health  Condition  Dementia  Mental Illness  Sensory Impairment Hearing  Substance Misuse    **Please give a brief outline of how your caring role affects you:** | |
| **Do you provide care and support for more than one person**  Yes  No  If Yes, please tell us about second person on page 5. | |
| **What would be your preference in terms of support:**  Newsletter only  Benefits advice  Peer groups/hubs/events  Email support  Telephone support  Face to face support (Home/ office visit) | Benefits advice  General advice  Carers Assessment of Need  Planning for an emergency (CEC)  Other support (please state below) |
| **How did you hear about York Carers Centre:**  York Carers Centre leaflet or poster ☐ Event/support group  GP surgery  Other health worker / hospital  Web search (for example, Google)  Twitter or Facebook  Friend or relative | Event/support group  Article in a newsletter/newspaper  City of York Council ☐ Job Centre Plus  Other (please say how below) |
| **Name and contact details of person completing this form:**  **If professional, name of organisation: Job Title:** | |
| **Information required if asking for a Carers Assessment of Need:**  For more information, a Carers Assessment of Need factsheet is available in our information pack or on our website [www.yorkcarerscentre.co.uk](file:///\\yc-dc01\users$\emma.keef\Desktop\www.yorkcarerscentre.co.uk). Please complete these pages if you would like to request an adult Carers Assessment of Need. The carer and person cared for must be over 18. | |
| **Consent for sharing information**  I understand that information on this form will be used to assess my need for help advice and support and to manage and plan services for me now and in the future. I understand that CYC and York Carers Centre will only share the information provided by me with other organisations and/or the person or people I care for, on a need to know basis in order to provide me with help and support. All information will be held in accordance with the Data Protection Act 1998. I understand that I have a right to see information held by CYC and York Carers Centre about me at any stage.  Do you consent to this?  Yes  No  Name: Signature: | |
| **Supporting the person you care for:**  I am providing care and support that is “necessary” as the person I care for is not capable of meeting these needs themselves. Yes  No    Do you provide help with any of the following? Tick all the boxes that apply.  Washing/dressing  Domestic support  Mobility/transport  Meal preparation/help with eating/drinking  Help with using the toilet  Supervision/emotional support/prompting/guidance  Support with medication/health needs  Support with finances/correspondence  Developing and maintaining family or other personal relationships  Helping with caring responsibilities the adult has for a child  Accessing and engaging in leisure activities/work/education/volunteering or community facilities  **Additional details: (Please give an indication of frequency of support you provide?)**  **Does the person you look after receive any other support and if so, please provide details (e.g. social worker or care manager, paid carers, sitting services, equipment, friends, family etc.)**  Yes No  Details:  If social care assessment required, please signpost carer to CYC Customer Access and Assessment Team: 01904 555111. | |
| **What would be your preference in terms of method of carers assessment:**  Depending on your circumstances, and if you request a face to face visit, your carers assessment may be completed with a Carers Support Worker from either York Carers Centre or City of York Council. Alternatively you can complete your own carers assessment by visiting our website: [www.yorkcarerscentre.co.uk](http://www.yorkcarerscentre.co.uk) . There is also a factsheet and guidance available.  Self Assessment online (please visit website)  Self Assessment via post (we will send the form and guidance to you)  Supported Assessment via phone (we will contact you to arrange a telephone appointment)  Supported Assessment in person (we will contact you to arrange a visit at a place of your choice) | |
| **Any other information:** | |
| **Please return this form to:**  York Carers Centre  17 Priory Street  York YO1 6ET  Email: [enquiries@yorkcarerscentre.co.uk](mailto:enquiries@yorkcarerscentre.co.uk) Tel: 01904 715490 | |

   

**Company Registration Number:** 06760783 **Charity Registration Number:** 1127644

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| **Information about the second person you care for** |
| **Name:**  **Date of Birth:**  **What is your relationship to this person you care for?**  Spouse or Partner Friend Child  Parent Other Relative  Neighbour  **Do they live at the same address as you?** Yes  No  Address if different to yours: |
| **What is the primary reason for their needing care or support from you?**  (Please tick one box only)  Neurological- Long Term Health  Condition  Dementia  Mental Illness  Sensory Impairment Hearing  Substance Misuse    Physical- Long Term Health Condition  Frail Elderly  Learning, Developmental or Intellectual  Disability  Sensory Impairment Visual  Dual sensory impairment  Other  **Please give a brief outline of how your caring role affects you:** |

   

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