**Logan Housing Care Coordination Group: Referral and Consent Form**

Logan Housing Care Coordination Group is a group of agencies working together to achieve better outcomes for People who are homeless or at risk of homelessness. This Group holds care coordination meetings every 2 weeks. This meeting brings together a range of agencies (listed below) who work together to achieve housing and support that can help a person to exit from homelessness and maintain existing tenancies. The members of this Care Coordination group are bound by a code of conduct that ensures that your details remain confidential within the context of case coordination.

Care Coordination Organisations may include representatives from the following areas:-

* Department of Communities, Housing, The Arts and Digital Economy
* Community Housing Services
* Domestic and Family Violence services
* Aboriginal and Torres Strait Islander Services
* Queensland Police Service
* Culturally and Linguistically Diverse Services
* Disability Service

**CLIENT CONSENT**

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| **Please read this privacy notice to the client:** |
| The information in this assessment is being collected by your referring agency and will be presented to the Care Coordination Group participating agencies. Participating agencies will discuss this information based on your consent to provide assistance through the coordination of support services and housing services.  Information collected will be stored in the Department of Communities, Housing, the Arts and Digital Economies’ Client Management System. This information can only be accessed by the Regional Care Coordinator and departmental staff. From time to time de-identified information will be used for case studies or may be used for research purposes.  Please note that information held by Logan Housing Care Coordination Group and its participating agencies is subject to the provisions of the Right to Information Act 2009 and National Privacy Laws. |

By signing this, I agree to have my details presented at the Care Coordination Meetings by my key agency for assistance with housing and other support services.

I understand that staff from a Case Coordination Group participating agency may both seek and provide further specific information from or to staff from organisations participating to assist with my housing and support needs. Any information that is collected will be stored in a secure and confidential manner and will only be used to help achieve the support plan I have agreed to with my key support worker.

I understand if I have any questions or concerns about this data sharing that I can contact my key worker at any time. It has been explained to me that **if I don’t give consent to being assisted through the Case Coordination Meeting, I am still eligible for other types of assistance from individual agencies**.

I understand that **I can withdraw consent for participation in case coordination** at any time by telling my keyworker.

You also have the right to access information about you at any time by requesting this from your key worker.

Name …………………………………………………………………

Signature……………………………………………………………..

Date…………………………………………………………………….

**Verbal Consent**

Verbal Consent is only required if clients signatures are **NOT** collected (see above)

All components of this form have been discussed with the Client or their Carer and they have consented to their details being presented at the Care Coordination Meetings

Referring Staff Member Name…………………………………………………………

Referring Staff Member Signature…………………………………………………….

Date………………………………………..

The below information is provided to the LHCCG members and will be discussed at a Care Coordination

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| --- | --- |
| **REFERRER’S DETAILS/KEY CONTACT INFORMATION** | |
| Date Of Referral |  |
| Referrer Name |  |
| Organisation |  |
| Position |  |
| Phone contact |  |
| Email |  |

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| --- | --- | --- | --- |
| **REFERRAL DETAILS** | | | |
| **Name** | *Provide if consent has been obtained. If not, de-identify.* | | |
| **Date of Birth** |  | **Gender** |  |
| **Address** |  | | |
| **Housing Application Status** |  |  | |
| **Specialist Homelessness Service** | *Has a referral been made if so what was the outcome* |  | |
| **Accommodation Type** | Private Rental  Supported Accommodation  Inpatient | Homeless  Social Housing  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Does the Person Identify As:** | Aboriginal  Torres Strait Islander | Both Aboriginal and Torres Strait Islander  Neither Aboriginal nor Torres Strait Islander | |
| **Ethnicity** |  | **Interpreter** | Yes  No |
| **Living situation** | Couch surfing    Transitional housing  public housing at risk  rental housing at risk  Rough sleeping | Crisis accommodation  House sharing  community housing at risk  boarding house at risk  Caravan park | |

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| **Household Composition** | Single person living alone  One parent with children  Couple  No. of Children  Ages of Children | Two parents with children  Other family type with children  Family other (such as siblings)  Any other household members not listed: |
| **Income Source** | Wages  Youth Allowance  Parenting payment  Other – pension, Child Support etc. | DSP  Newstart Allowance  Aged pension  Rent assistance |
| **Presenting Issues** | Housing and homelessness  Drug and/or alcohol  Legal including debt  Health  Domestic violence &.or Abuse  Personal care and basic needs | Mental health  Employment and training  Family relationships  Social and community connections  Child safety  Income  Survival and safety |

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| **Reason for Referral:** Include the goals of the person, background leading to the current situation, what has already been tried, what barriers are being experienced, identified risks, what outcomes are sought from the LHCCG. |
| **Background/Contextual Information:**  **Barriers/Complexities:**  **Identified key risks:**  **What has been tried:**  **Solutions/Outcomes Sought:** |

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| **Involved Stakeholders:** Formal and Informal | | | |
| **Stakeholders Name** | **Organisation** | **Role/Supports Offered** | **Issues** |
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