Linking Communities Network Ltd Referral Form

Please return via email to lcn@lcn.org.au

Privacy Statement: Linking Communities Network Ltd collects your personal information in order to provide assistance, support and advocacy to clients. This information will provide important statistics and help us find the most suitable service to suit your needs. Your personal information is protected under law and will not be passed on to anyone without your consent.

Question for client:

Do you provide consent for your personal information (name, sex, date of birth and suburb), the date you applied for assistance and the name of this service; to be available to other government and non-government homelessness services in NSW for one year after today's date?. Your personal information will be managed in accordance with the *Information Privacy Act 2009.*

I consent to the disclosure of my personal information to other state or commonwealth government agencies and/or non-government community agencies in order that community recovery services can be provided to address my identified needs.

Date: _____ **** Client Signature:** _____

OR ☐ ***Verbal consent***

(The client/applicant has been read the above privacy statement, indicated that they understand what it means and have given their verbal consent to the above)

**Consent is valid for one year from date of signing unless otherwise stated

1. INITIAL REFERRAL INFORMATION

Date of initial referral				
Type of Referral (insert tick in appropriate section)	Referral from Department of Communities and Justice ☐	Referral from community organisation ☐	Self-referral ☐	Other referral/Internal ☐
Referring agency details	Worker name			
	Organisation name			
	Contact details			
Priority	Urgent ☐		Non Urgent ☐	

2. PRIMARY CLIENT DETAILS

Name (Miss / Ms / Mrs / Mr)	Title		Surname	
	First name			
Address	Current Address			
Phone	Mobile		Home	
Gender	Male ☐		Female ☐	
Date of birth		CALD ☐	ATSI ☐	
Email address				
Preferred language (if other than English)		Is an interpreter required?	☐ YES	☐ NO

Type of assistance required – Accommodation ☐ Support Only ☐

Provide comprehensive description below to assist referral:

Existing client of a service agency (eg disability services, mental health service) **or referred to another agency. (If yes, what agency?)** Enter Agency	☐ YES ☐ NO ☐ UNSURE

Composition of household (which of the following best describes the composition of the household)	☐ Single Person ☐ Couple with dependants ☐ Couple – no dependants	☐ Single Parent ☐ Other – Please Specify below: Click here to enter text.	How many people currently live in the household: Click here to enter text.

Name of Dependent	Date of Birth	Name of Dependent	Date of Birth

3. Program Referring To within LCN

PROGRAM	ADDITIONAL INFORMATION			
a) Youth Links	☐		**Please note LCN do not provide mental health services, please refer to appropriate mental health agency**	
b) Links For Women	☐		**Please note LCN do not provide mental health services, please refer to appropriate mental health agency**	
c) Child, Youth and Family Services	☐		**Please note LCN do not provide mental health services, please refer to appropriate mental health agency**	
d) Women's Domestic Violence Court Advocacy Service	Before Court support At court support	☐ ☐	After court support	☐
e) Staying Home Leaving Violence	Information on referral process (Griffith only)	☐	**NB:** Separate referral required for SHLV	

Please ensure this referral is emailed to lcn@lcn.org.au

LCN Office Use only:

Referrer notified of assessment outcome: Date: _____
Client Eligible / Not Eligible (Please circle)