# Eligibility Criteria (Please tick):

The applicant is a Singaporean citizen or Singapore Permanent Resident.

The applicant is above 18 years old.

The applicant is free from infectious diseases.

The applicant is not abusing drugs/alcohol currently.

The applicant is not suffering from serious psychotic disorders and/or serious behavioral problems that require close individual supervisions or nursing care.

The applicant is rendered homeless and/or in crisis.

The applicant has explored other options with kinship support but to no avail.

The applicant is currently employed/fit for employment.

The applicant can pay monthly shelter fees (SGD $100 per month, excluding utilities).

Requested date of admission into shelter:  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested length of time in shelter: day(s)/week(s)/month(s) (max. 6 months)

*Note: If the applicant does not fulfil the above criteria, please provide supporting reasons for this request in the field*

*“Assessment by Social Worker” at the second page of this form.*

# Required Documents:

Social Report

CPF statements

Employment letter/ Salary slips

Relevant documents pertaining to HDB/housing

Bank Statements (if any)

Medical Reports/Memos

**Annex A**

Sheet No

**REFERRAL FORM**

**PART 1: To be filled up by Referring Agency**

## CLIENT’S PARTICULARS

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | | |
| NRIC No. |  | | | Nationality | | |  | |
| NRIC Address |  | | | | Singapore | | |  |
| Telephone No | Hp |  | | | H |  | | |
| Age |  | | Date of Birth | | |  | | |
| Marital Status |  | | No of children | | |  | | |
| Language Spoken | English  Mandarin  Malay  Tamil  Others\_\_\_\_\_\_\_ | | Education | | | Degree  A Level  O Level  Lower Secondary  PSLE  Others\_\_\_\_\_\_\_\_\_ | | |
| Ethnicity/Race | Chinese  Malay  Indian  Others\_\_\_\_\_\_\_ | | Religion | | | Buddhism  Christianity  Catholic  Hindu  Islam  Others\_\_\_\_\_\_\_\_\_\_ | | |
| Earliest Date Of Release (EDR) |  | | Prison Inmate  Number | | |  | | |

## FAMILY COMPOSITION

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Relationship with resident | Age | Occupation |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## EMERGENCY CONTACT NUMBERS (Please list two persons)

|  |  |  |
| --- | --- | --- |
| Name | Relationship | Contact Number |
|  |  |  |
|  |  |  |

## AFTERCARE CASE MANAGER DETAILS (If any)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name |  | | | | |
| Designation & Agency | | |  | | |
| Contact No | |  | | Email |  |

**CHECKLIST**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Forensic/Criminal History** | History of sexual assault  Please specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  History of violent/hostile/aggressive behaviour  Please specify : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  |  | | --- | --- | --- | | **Incarceration History** | | | | **Offence Number** | **Type of Offence** | **Period of incarceration (MM/YY to MM/YY)** | | 1st |  |  | | 2nd |  |  | | 3rd |  |  | | 4th |  |  | | 5th |  |  | | 6th |  |  | | 7th |  |  | | 8th |  |  | | 9th |  |  | | 10th |  |  | |
| **History of Substance use and Dependency** | Types of substances taken and frequency of use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Number of times in DRC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Details of Offences: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Urine Test (UT) days (please tick):  Mon  Tue  Wed  Thu  Fri  Location of UT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Mental/Medical Health Issue** | Current Mental/Medical Health issue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Active/impact daily functioning  Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Stable/little impact on daily functioning  Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  | | --- | --- | | **List of medication** | | | **Name of medication** | **Consumption Instructions** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |
| **Housing History** | |  |  | | --- | --- | | **Housing Type (rental/purchase)** | **Period of stay(MMYY)/ownership status (Owner/Occupier/Co-tenant)** | |  |  | |  |  | |  |  | |  |  | |  |  | |
| **Systems client known to** | |  |  |  |  | | --- | --- | --- | --- | | **Name of organisation** | **Type of Assistance** | **Officer-in-charge** | **Contact Details** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Assessment** | Motivation level to work on securing full-time employment:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Motivation level to work on housing plan:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Strengths:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Potential challenges:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

ADDITIONAL REMARKS ABOUT CLIENT

|  |
| --- |
|  |

Referring Staff declares that consent has been granted by the client to allow his personal data to be collected, used and disclosed to Transit Point @ Spooner for the purpose of applying for shelter assistance.

Referring Agency will continue to co-manage the referred client

|  |  |
| --- | --- |
| Name of Referring Staff: |  |
| Designation: |  |
| Referring Agency: |  |
| Contact Numbers: |  |
| Email: |  |