

# Sonas

a path to a  
new future

## Referral Form

**Applicant's Name:**

**Referring Agency:**

**PLEASE COMPLETE THIS FORM IN THE PRESENCE OF APPLICANT**

**All applications are subject to background checks**

**SONAS HOUSING ASSOCIATION LIMITED**

**14 Bachelor's Walk**

**Dublin 1**

**Telephone: 01 8720068**

**Fax: 01 6865005**

**Email: [applications@sonashousing.ie](mailto:applications@sonashousing.ie)**

**Web: [www.sonashousing.ie](http://www.sonashousing.ie)**

**Co. No. 195618. CHY.10872**



# Introduction

- » Please fill in this form along with the applicant.
- » Please read the form carefully and answer all of the questions.
- » The information which you supply will be treated in the strictest confidence and will not be made available without your permission to anybody other than the Applicant.
- » Supplying false information will result in a disqualification of the application.
- » Please return your completed form to:

Sonas Housing Association  
14 Bachelor's Walk  
Dublin 1  
Telephone: 01 8720068  
Fax: 01 6865005  
Email: [applications@sonashousing.ie](mailto:applications@sonashousing.ie)  
Web: [www.sonashousing.ie](http://www.sonashousing.ie)

## Data protection

All information provided on this form and any associate documents will be held on a secure filing system. Details of an applicant's case will not be discussed with any other person, organisation or statutory body without an applicant's full consent. Sonas applicants have a right to see their files at all times.

# 1. REFERRING AGENCY DETAILS

1.1 Agency name:

1.2 Please tick the box that describes your organisation

- |   |   |  |
|---|---|--|
| Women's refuge <input type="checkbox"/>             | Community services <input type="checkbox"/>           | Addiction services <input type="checkbox"/>        |
| Domestic violence services <input type="checkbox"/> | Local authority <input type="checkbox"/>              | Primary care service <input type="checkbox"/>      |
| Hospital <input type="checkbox"/>                   | Mental health service <input type="checkbox"/>        | Probation service <input type="checkbox"/>         |
| Therapist <input type="checkbox"/>                  | Transitional housing service <input type="checkbox"/> | Traveller support service <input type="checkbox"/> |
| Other <input type="checkbox"/>                      |   |  |

If other please give details:

1.3 Address:

1.4 Telephone number:

1.5 Email address

1.6 Name of keyworker:

1.7 When is the best time to contact you?

Morning  Afternoon

If you work irregular shifts please provide an alternative contact person:

Please note this person should be actively working with the applicant & familiar with her history

1.8 Applicant's name:

1.9 Applicant's date of birth:

1.10 How many children does the applicant have:

## 2. APPLICANT DETAILS

2.1 When did the applicant come to your service?

2.2 Was this a self referral? Yes  No

If no, who referred the applicant?

2.3 How long has the applicant been using your service?

Less than one month  One-to-three months

Three-to-six months  Six-to-twelve months  Over 12 months

If over 12 months, please specify the period:

2.4 On average how often do you meet with the applicant?

Daily  Biweekly  Weekly  Fortnightly  Other

If other please specify how often:

2.5 Has the applicant stayed in a Women's Refuge? Yes  No

If yes, which Refuge(s)?

If yes, how often has she stayed?

If yes, what dates did she stay?

2.6 Has the applicant used Homeless Services\*? Yes  No

If yes, which service(s)?

If yes, how often has she used the service(s)?

If yes, what dates did she use the service?

\*Sonas may need to contact any or all of the above housing services

2.7 To your knowledge has the applicant been referred to:

Community care  Social work  Mental health services  Legal aid services  other

If other, please specify what service:

If you ticked any of the boxes, when was the applicant referred?

If you ticked any of the boxes, what was the reason for referral?

If applicable, what organisation referred her?

### 3. HISTORY OF THE RELATIONSHIP

3.1 Has your service had contact with the applicant's violent partner/abuser? Yes  No

If yes, please describe the nature of the contact:

3.2 Do you think the applicant's ex-partner poses a threat? Yes  No

If yes, please explain:

3.3 In your opinion do you think the applicant is finished with the relationship/ ready to sever ties with her abuser/ to move on with her life? Yes  No

Please explain fully:

3.4 Please detail any other information about the applicant's ex-partner that you think is relevant:

### 4. ACCOMMODATION HISTORY

Please note all applications are subject to background checks being satisfactory

4.1 Is the applicant currently a:

Housing association tenant\*  Local authority tenant\*  Private rented tenant  A homeowner\*\*

\*If so, with which association/authority:

\*\*Is the applicant a joint home-owner? Yes  No  If yes, please give details about the nature of the home-owning arrangement:

4.2 To your knowledge, has the applicant ever been evicted or been involved in anti-social behaviour?

Yes  No

If yes, please give more information:

## 5. LEGAL HISTORY

5.1 Do you think legal action would benefit the applicant? Yes  No

If yes, please explain:

5.2 In your opinion is the applicant willing to use the legal remedies available to her to ensure her safety? Yes  No

Please explain:

## 6. HEALTH

6.1 To your knowledge, has the applicant ever presented with any mental health difficulties? Yes  No

If yes, please give details:

6.2 To your knowledge, does the applicant have a history of self harm and/or suicide attempts? Yes  No

If yes, please give details:

## 7. ADDICTION

7.1 To your knowledge, does the applicant have a known history of alcohol dependency? Yes  No

7.2 To your knowledge, does the applicant have a known history of drug dependency? Yes  No

7.3 Is the applicant currently on a treatment programme? Yes  No

Please give full details.

7.4 If yes, in your opinion how does the applicant engage with her programme?

## 8. CHILDREN

8.1 Is your service currently providing support in relation to children? Yes  No

If yes, please describe the support

8.2 To your knowledge, are there any Child Protection or Welfare concerns? Yes  No

If yes, please give details and indicate whether or not a referral has been made to Community Care Social Work department

8.3 Is there a social worker assigned to the family? Yes  No

Please ensure that contact details are given in children's section of application form

8.4 Have the children been referred to any other agency/service? Yes  No

If yes, please give full details including the status of the referral:

8.5 If you can, please give your observations of the child/children's needs and ability to interact with adults and other children:

## 9. SUPPORT NEEDS

9.1 How do you think the applicant would benefit from the Sonas service?

9.2 What areas of support do you think the applicant needs from Sonas?

<input type="checkbox"/> Support with safety issues	<input type="checkbox"/> Information on local activities or social groups
<input type="checkbox"/> Support to make life changes	<input type="checkbox"/> Information on counselling options
<input type="checkbox"/> Support with personal organisation and/or housekeeping skills	<input type="checkbox"/> Support with budgeting and managing money
<input type="checkbox"/> Talking to someone who understands situation	<input type="checkbox"/> Support getting safe and adequate housing
<input type="checkbox"/> Learning more about why/how domestic violence happens	<input type="checkbox"/> Support with legal orders (barring, safety or protection order)
<input type="checkbox"/> Someone to go with applicant to court	<input type="checkbox"/> Information about the legal system process
<input type="checkbox"/> Information about her legal rights and options	<input type="checkbox"/> Information about social welfare benefits and entitlements
<input type="checkbox"/> Support with court case against the person who abused her	<input type="checkbox"/> Support getting access to mental health services
<input type="checkbox"/> Support getting access to healthcare	<input type="checkbox"/> Support meeting applicant (or applicant's child's) needs in relation to a disability
<input type="checkbox"/> Support getting access to substance abuse services	<input type="checkbox"/> Independent living skills
<input type="checkbox"/> Help getting support from religious community	<input type="checkbox"/> Support understanding rights and options related to residency status
<input type="checkbox"/> Support dealing with sexual abuse services for applicant or children	<input type="checkbox"/> Support getting residency status
<input type="checkbox"/> Support with safe visitation for children	<input type="checkbox"/> Support getting child maintenance
<input type="checkbox"/> Support with children's school	<input type="checkbox"/> Support with custody issues
<input type="checkbox"/> Other. Please give details:	

9.3 What informal support structures does the applicant have in place?

Support from family  Support from friends  Support from case worker

9.4 Please give details of applicant's support structures:

9.5 To your knowledge has the applicant ever lived alone? Yes  No  If Yes, for how long?

## 10. DECLARATION

Note: If the referring agency offers a specialist service, ie a mental health service, Sonas may request a contract/commitment to remain involved in the applicant's case until she is transferred to an equivalent service in her new area. No tenancy will be offered without this undertaking.

Please read the declaration below and sign underneath:

The information I have given on this form is to the best of my knowledge and belief, accurate. I understand that supplying false information will result in disqualifying my application.

Signed for the service:

Position:

Applicant's signature:

Date: