The Lismore Rough Sleepers Project provides short-term accommodation of 3-6 months for homeless people in the Lismore Local Government Area. This project provides 4 x 1 and 2 bedroom properties in Lismore. This accommodation can be share accommodation, if appropriate.

The Rough Sleepers Project is a partnership project between North Coast Community Housing Company, Housing NSW, Department of Ageing Disability and Homecare and NSW Area Health Service. These parties make up the Rough Sleepers Working Party, with a NGO representative. North Coast Community Housing Company will provide tenancy management for the program, while the referring agency will provide the support to the client, along with any other involved support agencies.

In order to be eligible for the Rough Sleepers Project a client must be:
- Eligible for Public Housing
- (Must be on Housing NSW waiting list and have a T-File Number)
- Homeless or at risk of homelessness
- Require support to live independently
- Have a case plan in place and be willing to work with support agencies to address their needs

In order to make a referral to the Rough Sleepers Project, the following documentation is required:
- FORM A – Referring Agency Details
- FORM B – Client Assessment
- FORM C – Living Skills Assessment
- FORM D – Risk Assessment Form
- FORM E – Support Plan/Case Plan detailing what support will be provided to the client and by whom
- Client Information Consent Form
- An Income Statement form Centrelink

This documentation must be faxed through to North Coast Community Housing Company. The referral will be considered at the next Rough Sleepers Working Party Meeting. You will be advised of the outcome of this referral in writing following the Working Party meeting.

Due to the need for applications and client information to be current, the Rough Sleepers Project does not maintain a waiting list. Applications will be sought from local agencies at the time of a vacancy arising within the project.
Lismore Rough Sleepers Project

REFFERING AGENCY DETAILS

Date of Referral: _______________________________________________________

Name of Agency: _______________________________________________________

Address: _______________________________________________________________

Phone: _________________________________________________________________

Email: _________________________________________________________________

Fax: __________________________________________________________________

Contact Person 1: _______________________________________________________

Contact Person 2: _______________________________________________________

Please fax completed referrals to North Coast Community Housing Company on Fax: 66224261

Office Use Only

Date Received: 

Date of Selection Panel: 

Outcome: 

☐ Eligible ☐ Approved

☐ Ineligible ☐ Declined
CLIENT ASSESSMENT FORM

1. **Client Details**

Name of Client: __________________________________________________________

Client D.O.B: ___________________________________________________________

Country of Birth: _______________________________________________________

Aboriginal or Torres Strait Islander: □ Yes □ No

Living in Lismore LGA: □ Yes □ No

Date of Assessment: ______________________________________________________

Assessment Conducted By: ________________________________________________ (name/agency)

Household Details:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>D.O.B</th>
<th>Type of Income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please attach proof of income such as Centrelink Income Statement to this referral

Is the client currently on Housing NSW’s waiting list for public housing? □ Yes □ No

- **IF YES**, what is the clients T File Number:
  ________________________________

- **IF NO**, the client will need to make an application for public housing and obtain a T File Number. Housing NSW can be contacted on 66232424 and is located at level 4, 29 Molesworth St. Lismore.
2. **Current Living Situation**

Where is the client currently sleeping?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

When did the client begin sleeping there?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Where was the client sleeping before this?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What led to the client becoming homeless?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please describe the client’s previous housing history:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

3. **Client Housing Requirements**

a) Does the client have any medical or physical condition, which affects their need for housing or the type of housing they require?
Please provide details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
b) Does the client have any special housing requirements (eg: no stairs, level access, grab rails, modifications etc) which need to be taken into consideration? Please provide details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

__________________________________________

c). Are there any barriers to the client sharing accommodation? Please provide details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

4. **Client Support Needs**

Does the client have one of the following, which may affect their ability to sustain a tenancy?

- a) Psychological Disability  
  - [ ] Yes  
  - [ ] No
- b) Intellectual Disability  
  - [ ] Yes  
  - [ ] No
- c) Psychiatric Illness  
  - [ ] Yes  
  - [ ] No
- d) Dependence Issue  
  - [ ] Yes  
  - [ ] No

Please provide details of the above:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

What support or treatment is the client currently receiving for this? Please provide details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Does the client have a carer or any family, friends or support agencies that can assist them to sustain a tenancy? Please provide details:

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
Does the client have any debts or excessive medical expenses that might impact upon their ability to pay their rent?
Please provide details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does the client need help with any of the following?

a) Medical treatment ☐ Yes ☐ No
b) Financial counselling ☐ Yes ☐ No
c) Mental Health counselling/treatment ☐ Yes ☐ No
d) Drug/Alcohol counselling/treatment ☐ Yes ☐ No
e) Domestic Violence counselling ☐ Yes ☐ No
f) Living skills training ☐ Yes ☐ No
g) Referral to a home help/personal care service eg. Home Care ☐ Yes ☐ No

Please provide details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Is the client willing to accept help with these issues? ☐ Yes ☐ No

Does the client, or their guardian/person responsible, agree to participate in a multi-agency case management planning process? ☐ Yes ☐ No

Please identify any risks or issues related to the client’s capacity to successfully sustain a tenancy:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

What needs to be done, or is being done, to address these risks or issues?
Please provide details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
LIVING SKILLS ASSESSMENT

A). FINANCIAL MANAGEMENT

Who manages the client’s finances?

☐ Self - managed
☐ Office of the Protective Commissioner
☐ Family Member
☐ Other

Please provide details including name and contact number:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

B). PROPERTY CARE

In your professional opinion does the client have the ability to maintain their home in a satisfactory condition with the current level of support?

☐ ☐ Yes ☐ ☐ No

If No, what additional support or referrals are required? Please provide details:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

C). PERSONAL CARE

In your professional opinion does the client have the ability to look after their day-to-day personal care needs without support?

☐ ☐ Yes ☐ ☐ No

If not, why not, and what additional supports or referrals are required?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

D). SOCIAL INTERACTION

In your professional opinion, is the client able to live in close contact with others without causing nuisance and annoyance?

☐ ☐ Yes ☐ ☐ No

If No, please provide details as to why:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

FORM C
In your professional opinion, does the client have the ability to be responsible for their own conduct as well as the conduct of their visitors?

☐ ☐ Yes  ☐ No

If No, please provide details:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Outline below any other issues relevant to the client's ability to live independently that the Rough Sleepers Working Party needs to take into consideration:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

The Living Skills Assessment is now complete.

Support Worker Name:
________________________________________________________________________

Support Worker Signature:
________________________________________________________________________

Date: ____________________________
### Rough Sleepers Risk Assessment

**NAME:**

<table>
<thead>
<tr>
<th>ISSUE</th>
<th>Category</th>
<th>Risk Plan in Place</th>
<th>Support plan in place</th>
<th>Additional Support required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rough Sleepers Risk Assessment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Aggression: Examples of low/moderate/high are listed for each category; LOW: irritable, verbally abusive MOD: property damage HIGH: assaults other people</td>
<td>Y</td>
<td>LOW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk to Physical Health: LOW: poor diet, non attendance to GP MOD: refusal to follow up diagnosed conditions e.g. Diabetes HIGH: serious health problem, not cooperating with treatment</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Risk of Self Harm: LOW: no real suicide or ideation MOD: personal harm risk behaviours HIGH: suicide plan, suicidal behaviours</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Potential for social disruption: LOW: loud noise, poor sleep pattern MOD: intrusive towards others, offensive behaviour HIGH: intrusive results in conflict, violence</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Risk of social isolation: LOW: minimal social supports, but basic need met. MOD: dissatisfaction with lack of social contact. HIGH: social isolation affects mental health</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Drug and Alcohol Issues: LOW: loss of self control, not seriously addicted. MOD: craving or dependence on alcohol/drugs. HIGH: incapacitated by alcohol/drugs</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Risk of Vulnerability: LOW: gives away money, cigarettes MOD: fails to seek help HIGH: exploited by others physically, emotionally and/or sexually.</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>Risk to Safety: LOW: failure to lock doors MOD: fire risks e.g. leaves stove on, cigarettes burning. HIGH: blatant disregard to safety, irresponsible behaviour.</td>
<td>Y</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
<tr>
<td>SCORE: Add total ticks for each category</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
<td></td>
</tr>
<tr>
<td>CASE PLAN</td>
<td>FORM E</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue/s facing the client</td>
<td>Agency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategy to address issue/s</td>
<td>Name/title of position responsible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>[personal goals of the client]</td>
<td>Time frame for involvement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barriers [what’s keeping them from getting there?]</td>
<td>Frequency of contact with client to address issue/s and outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>