

**Ref No.**

**Together Everyone Achieves More**

**Cyflawni Mwy Gyda’n Gylydd**

**Blaenau Gwent Families First/SPACE Wellbeing**

**Request for Support Form**

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| **Type of Request:** | Initial Request Self-RequestRe-request | Step Down Request Space Wellbeing **Is the family remaining open to SSD? Y/N*****Please attach Integrated Assessment/last Care & Support Plan***  |
| **Family Name/Names:** |  |
| **Address:** |  |
| **Telephone Number/s:** |  |
| **Previous Addresses:** |  |
|  |
| **Previous JAFF Assessment:** | **Yes 🞏** | **No 🞏** |
| **Is this a Flying Start Family:** | **Yes 🞏** | **No 🞏** |
| **Does any family member have needs relating to a disability?** | **Yes 🞏** | **No 🞏** |
| **Family affected by imprisonment?** | **Yes 🞏** | **No 🞏** |
|  |
| **Details of person making the request for support** |
| **Name of Agency:** |  |
| **Name & Contact Details of Worker:** |  |
| **Worker’s Signature** |  |
| **Date of Completion** |  |
| I understand that the information in this form will be added to the Families First database and may be shared with other service providers in order to meet my needs. This database is used by Families First for administration, service delivery and monitoring and evaluation.I understand that the data will be stored and shared in accordance with the Data Protection Act 1998.  |
| ***Has informed consent been obtained from the Family/Young Person/Child to make this request:***  |
| **Yes: Verbal: Written:**  |  |
| **No: If not, why not:**  |  |
| **Brief Summary of Family Circumstances:** |
| **Reason for Request for Support/Support Required:** |
| **If this is a request for support from SPACE Wellbeing please complete the following:-**

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| **What help is the family expecting?****What is your opinion on presentation and expectation of this request***What is your understanding of child/young person/family’s presenting issues? What are you expecting from making this request for support? If available, please include relevant findings from education, social care, and/or other health examinations or assessments***What has already been tried to address the child’s or young person concerns***(Please include both self-help and support from professionals. Please indicate what has been helpful or unhelpful)* |
| Are there any risks associated with this family that Services should be aware of? | YES | NO |
| Additional information relating to **Risk** (Include safeguarding; personal safety, e.g. suicide / self-harm; risks to professionals, e.g. risks in the home environment) |  |

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| **WCCIS****Number** | **Status Within Family (e.g. Mother)** | **Surname** | **First Name** | **DOB** | **Gender****(M/F)** | **Ethnicity** | **Household Members** **Y/N** |
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| **Families First Office Use Only** |
| Outcome/Decision: |  |
| Signature: |  |
| Date: |  |
|  |
| **Please return form marked CONFIDENTIAL to:**Blaenau Gwent Families First TeamHeart of the Valleys Integrated Children’s CentreHigh StreetBlainaBlaenau GwentNP13 3BNEmail: familiesfirstduty@blaenau-gwent.gov.ukTelephone: 01495 355584 |