

Referral form

Child's first name..... **Guardian's** first name.....
 Child's last name..... Last name.....
 Child's NHI.....DOB.....Gender..... Phone number.....
 Address..... Mobile number.....
 Alternative contact person:
 Phone number:

Child's ethnicity: ☐ Māori ☐ New Zealand European ☐ Pacific Islander ☐ Other

Language preference (please tick)? English ☐ Other (please specify).....

Eligibility criteria – clients must meet the following three criteria:

(a) Live in the Northland DHB catchment area (from Te Hana in the south to Cape Reinga): Yes ☐

(b) Residency status (please tick one): New Zealand citizen ☐ New Zealand permanent resident ☐

(c) Have a Community Services Card (CSC): Yes ☐

– OR are eligible for one, using the CSC income thresholds below: Yes ☐

Family of 2: \$49 993

Family of 6: \$85 852

Family of 3: \$60 402

(For families of more than 6, the limit goes

Family of 4: \$68 682

up another \$7,986 for each extra person)

Family of 5: \$76 790

('Family of' means total number of people living in the home. This is not based on age or parental status. So a 'family of 4' could be two adults and two children, or one adult and three children, for example.)

How many people usually live in the home?.....

	Only <u>one</u> of the following are required	Yes <small>Please tick</small>
1	Is the client aged from 0 to 5 years and hospitalised within the last 12 months – <i>or is at risk of hospitalisation due to their housing conditions</i> – with one of the following indicator conditions: LRTI, pneumonia, bronchiolitis, meningitis, TB, GAS sepsis, meningococcal disease, positive strep GN, Rheumatic Fever?	
2	Is the client a parent with a baby up to six months of age?	
3	Is the client pregnant?	
4	Does the family have a child aged 0 up to 5yrs with at least two of the following social risks (Child Youth and Family finding of neglect or abuse, caregiver of child with a corrections history, long term benefit receipt, or mother has no formal qualifications – evidence not required)	



OR if your client meets one of the following criteria (questions 5 – 8), they must also answer yes to questions 9 & 10 (report functional or structural household crowding and have an additional child aged 0 –19 living with them).

5	Is the client receiving monthly Bicillin Injections for Rheumatic Fever?	
6	Has there been 3 positive Strep A results from the household in the last three months? (if yes please write dates below) (1)..... (2)..... (3).....	
7	Is the client aged 0 –14 years of age with bronchiectasis been hospitalised in the last two years?	
8	Is the client aged from 5 up to 14 years of age and recently hospitalised with one of the following indicator conditions: (LRTI, pneumonia, bronchiolitis, meningitis, TB, GAS sepsis, meningococcal disease, positive strep GN, Rheumatic Fever)?	

If you have ticked yes to one of the above (questions 5 – 8) then they must also answer yes to the two questions below

9	Is the home cold and / or damp and the family sometimes sleep together in one room to keep warm? (=functional crowding) or are there too many people for number of bedrooms? (=structural crowding)	
10	Is there an additional child or young person aged 0 –19 living in the house?	

Property status – Do you (tick one):	
Own your home?	Rent privately?
Live in a Housing NZ home?	Board with family or friends?

Referrer details

Referrer's first name..... Last name.....

Phone number..... Mobile number.....

Email..... Hospital.....

Service/team.....Date of referral.....

☐ I would like the Manawa Ora contracted Service Provider to contact me about this family. If yes, please specify reason:

.....

.....

If you are unsure whether a family is eligible or not, please complete a referral form, and the Manawa Ora team will contact you for further information if required.

Email: manawaora@manaiapho.co.nz Fax: (09) 438 3210

Melanie Dalziel (Regional Manawa Ora Coordinator):Phone: (09) 438 1015 or 021 415 665
Audrey Bridgman (Administrator):Phone: (09) 438 1015

Informed consent form

I / We _____

of

(address)

(address)

I am happy to be referred to the Manawa Ora Programme initiative to see if there are any services that will help to improve my housing situation.

Yes / No (please circle).

I am happy for the Manawa Ora service and their contracted providers to share my information between and / or with any other agencies that can / will be able to help improve my housing conditions.

Yes / No (please circle).

I am happy to be contacted again to see if my health and my home conditions have changed.

Yes / No (please circle).

(NB: Parent, legal guardian, caregiver to sign if young person is under 16 years).

(Name) (Signature) Date _____