Independent Care Act Advocacy (ICAA) Referral Form

Advocacy and the duty to involve

Local authorities must involve people in decisions made about them and their care and support. No matter how complex a person's needs, local authorities are required to help people express their wishes and feelings, support them in weighing up their options, and assist them in making their own decisions.

When does the advocacy duty apply?

The advocacy duty will apply from the point of first contact with the My Life Legacy and at subsequent stage of the assessment, planning, care review, safeguarding enquiry or safeguarding review. If it appears to the authority that a person or their carer has care and support needs, then a judgement must be made as to whether that person has **substantial difficulty** in being involved the above processes. If they do, and there is **not an appropriate individual** to support them, an **independent advocate** must be appointed to represent the person, essentially for the purpose of enabling and ensuring their full participation in decisions regarding their care, support or safeguarding.

Please complete a SEPARATE referral PER REFERRAL REASON

- If completing online, click on the dropdown menu to select the relevant answer and write in the fields, where required.
- If completing a hard copy, tick the relevant boxes and write in the text fields, where required.

Date of Referral:

REFERRER'S DETAILS

Are you making this referral for yourself? (self-referral) ☐ YES ☐ NO

If NO, provide referrer details below. (**If YES,** go to Referral SERVICE GROUP)

Referrer First Name:
Referrer Surname:
Are you referring on a professional basis? ☐ Yes ☐ No
Organisation (if applicable)
Job Title or Relationship to Client:

☐ Doctor	☐ Psychiatrist	☐ Ward Manager/Staff
☐ Care Manager	☐ Care Home Manager	☐ Team Manager Health
☐ Nurse/Health Professional (community)	☐ Social Worker (hospital)	☐ Social Worker
☐ Team Manager Social Care	☐ Administrator	
☐ Other / Non-Professional Relationship (specify)		

Referrer Address:
Postcode:
Tel No:
Mobile No:
Email: **Preferred method of contact?**

SERVICE GROUP

Is the person requiring an advocate….. (tick ONE box only)

☐ An older person (65+) in the community	☐ A carer	☐ None of these
☐ An older person (65+) in hospital	☐ A vulnerable person	

Are there disabilities or impairments considered particularly relevant to this case? (tick relevant boxes)

☐ Mental health problems	☐ Asperger's / Autism spectrum condition	☐ Learning disability
☐ Physical disability	☐ Cognitive impairment	☐ Dementia / Alzheimer's
☐ Sensory (hearing)	☐ Acquired brain injury	☐ Unconsciousness
☐ Sensory (sight)	☐ Serious physical illness	☐ None

CLIENT INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Other

First Name:

Surname:

Date of Birth:

Permanent Address:

Postcode:

Telephone No:

Mobile No:

Email:

Preferred method of contact:

☐ Any ☐ Telephone ☐ E-mail ☐ Post

☐ Mobile Phone ☐ Text ☐ Cannot be contacted directly

Gender:

☐ Male ☐ Female ☐ Transgender M to F

☐ Transgender F to M ☐ Prefer not to say ☐ Other (specify)

Ethnic Background:

White

British

Irish

Irish Traveller

Any other White Background (specify)

Asian/Asian British

Indian

Pakistani

Bangladeshi

Chinese

Any other Asian background (specify)

Mixed Ethnic Groups

White & Black Caribbean

White & Black African

White & Asian

Any other Mixed Ethnic Background (specify)

Other Ethnic Groups

Arab

Any other Ethnic Group (specify)

Black / Black British

African

Caribbean

Any other Black / Black British background (specify)

Sexual Orientation

☐ Lesbian ☐ Gay Man ☐ Heterosexual

☐ Bisexual ☐ Not Known ☐ Prefer not to say

☐ Questioning ☐ Other (specify)

Marital or Civil Partnership Status

☐ Single (partnership) ☐ Separated (but still legally married / in civil)

☐ Co-habiting ☐ Divorced or Civil Partnership Dissolved

☐ Married ☐ Widowed

☐ In Civil Partnership ☐ Surviving partner of Civil Partnership

☐ Not known ☐ Prefer not to say

Religion or Belief

☐ Buddhist
☐ Christian
☐ Hindu
☐ Jewish
☐ Not known
☐ Muslim
☐ Sikh
☐ No Religion
☐ Prefer not to say
☐ Other (specify)

Does the Client have a Military connection?

☐ Yes, serving
☐ Yes, veteran
☐ Yes, carer relationship
☐ No
☐ Not known
☐ Prefer not to say

Does the Client consider themselves to have a disability?

☐ Yes
☐ No
☐ Not known
☐ Prefer not to say

What types of disability or impairment does the Client have? **(select all that apply)**

☐ Mental health problem
☐ Physical disability
☐ Sensory (hearing)
☐ Sensory (sight)
☐ Asperger's / Autism Spectrum Condition
☐ Cognitive Impairment
☐ Acquired brain injury
☐ Serious physical illness
☐ Learning disability
☐ Dementia / Alzheimer's
☐ Unconsciousness
☐ Other (specify)

What is the Client's primary communication method?

☐ Spoken English
☐ British Sign Language (BSL)
☐ Words/Pictures/Makaton
☐ Other (specify)
☐ Other Spoken Language
☐ Gestures/Facial Expressions/Vocalisations
☐ No obvious means of communication
☐ Not known

Interpreter required? ☐ Yes ☐ No

CURRENT LOCATION DETAILS

☐ Own Home
☐ Own Home with Support
☐ Supported Living
☐ Acute Psychiatric Unit
☐ Dementia Ward
☐ Care/Nursing Home
☐ Prison
☐ Forensic Secure Unit
☐ Hospital
☐ Homeless
☐ No Fixed Abode
☐ Other Institution

Is Client currently at their permanent address? ☐ Yes ☐ No (if no give details)

Current Address:

Postcode: **Telephone No:**

ICAA REFERRAL DETAILS

LOCAL Authority of Referrer:

Referral Reason
(tick ONE box only)

An adult needs assessment ☐
A carer's assessment ☐
The preparation of a care and support plan or support plan ☐
The review of a care and support plan ☐
The review of a carer's support plan ☐
A child's needs assessment under Transition to adult care/support ☐
A child's carer's assessment under Transition to adult care/support to adult ☐
A young carer's assessment ☐
A safeguarding enquiry ☐
A safeguarding adult's review ☐

Does the person have Substantial Difficulty in: (select all that apply)	Understanding relevant information? ☐ Retaining information? ☐ Using up or weighing up information? ☐ Communicating views, wishes and feelings? ☐
Is the client subject to Mental Health Act Section 117 Aftercare?	☐ Yes ☐ No ☐ Don't know
Has there been the previous involvement of an IMCA in a decision?	☐ Yes ☐ No ☐ Don't know
Why does the person need an Independent Advocate? (the reason(s) why there is no 'appropriate individual'?) (select all that apply)	☐ Only paid professional help available ☐ No friend/family member available ☐ No preferred friend/family member available to them ☐ No friend/family member available without a vested interest ☐ Meditation through conflict/dispute with the local authority ☐ Other (specify)
Names and contact details of any others involved, or anyone to be consulted	
Please detail any visiting risks or complex behaviours that the advocate needs to be aware of when dealing with the referral. **If you are not aware of any risks, please write 'no known risks'**	

Describe the current circumstances of the client that have prompted the referral and explain what is requested of the advocate? Please provide dates of any meetings already planned?

Are you aware of any record of the person's wishes? ☐ Yes ☐ No

If Yes, please give details:

Emergency Contact Name:		
Emergency Contact Number:		
Emergency Contact Relationship:		
Where appropriate, has the client been made aware of the referral?	☐ Yes	☐ No
Where appropriate, has the client given their consent to the referral?	☐ Yes	☐ No
Are you satisfied the referral meets the criteria under the Care Act?	☐ Yes	☐ No

Declaration: I declare that I wish to request/instruct an Independent Care Act Advocate.

Name:……..

- I am providing this information and making this referral in relation to the Care Act 2014.
- In accordance with the General Data Protection Act 2016, I agree to My Life Legacy and its delivery partners holding personal information (including information on this form).
- I understand the provision of an ICAA from this advocacy service is subject to the client meeting eligibility criteria.

Please e-mail the completed form to: advocacy@my-life.org.uk

Or post to: My Life Legacy, No. 1, Smithy Court, Smithy Brook Road, Wigan, WN3 6PS

If you would like to discuss any aspects of a referral, please e-mail or call: 01257 472900 (press Option 2)

By requesting Advocacy support, you give consent to My Life Legacy sharing information as required for the purposes of providing the service. For more information on our privacy, data storage and data processing policies and procedures, please ask your advocate or go to www.my-life.org.uk. All records are held by My Life Legacy in accordance with current General Data Protection Regulations (2016).