North Northamptonshire Family Hub Network

REQUEST FOR SUPPORT

NB: REQUEST FOR SUPPORT TO BE FULLY COMPLETED AND IN BLOCK CAPITCALS OR TYPED; OTHERWISE, FORM WILL BE RETURNED.

****The support request will be assessed, and we will match parents, carers and families to the most appropriate service, dependent on your needs. Should it be identified that more than one agency is required, we will work with the family to complete an early help assessment with their consent.*

Please indicate which is the nearest Family Hub for you to access support:

Wellingborough Family Hub Network *Penrith Children's Centre*	☐	Corby Family Hub Network *Pen Green Children's Centre*	☐
Kettering Family Hub Network *Montague Street Children's Centre*	☐	East North Northants Family Hub Network *Virtual delivery utilising community buildings*	☐

Requester Details	
Requester Name:	
Requester Role:	
Requester Organisation / Agency:	
Requester Telephone:	
Requester Email:	

Family Details	
Name of Family or Individual:	
Address:	
Postcode:	
Home Telephone:	
Mobile Telephone:	
Parent/Carer Email:	

Please return your completed form to: SPAFamilyHubs@northnorthants.gov.uk

Please specify below which family member(s) require support:

Parent 1			
Name:			
D.o.B.:		Disabilities / Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
Requires Support:	Y / N	Parental Responsibility:	Y / N

Parent 2			
Name:			
D.o.B.:		Disabilities/Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
Requires Support:	Y / N	Parental Responsibility:	Y / N

Carer/Guardian			
Name:			
D.o.B.:		Disabilities/Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
Requires Support:	Y / N	Parental Responsibility:	Y / N

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Child / Young Person 1			
Name:			
D.o.B.:		Disabilities/Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
School Attended:		Requires Support:	Y / N

Child / Young Person 2			
Name:			
D.o.B.:		Disabilities/Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
School Attended:		Requires Support:	Y / N

Child / Young Person 3			
Name:			
D.o.B.:		Disabilities/Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
School Attended:		Requires Support:	Y / N

Child / Young Person 4			
Name:			
D.o.B.:		Disabilities/Health issues:	
Ethnicity:	Choose an item.	Language Spoken:	
School Attended:		Requires Support:	Y / N

Other agencies involved (currently or previously), e.g. GP, Social Services, CAMHS, Education Welfare, or other please specify;		
Name:	Agency:	Contact Details:

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Family Status: *(Please click on box to check)*		Family Composition: *(Please click on box to check)*	
One parent family:	☐	Home (both parents):	☐
Gender:		Home (one parent + partner):	☐
Male:	☐	Home (one parent):	☐
Female:	☐	Unknown:	☐
Other (please specify):	☐	Kinship Carer/s:	☐
Two parent family:	☐	Please specify relation:	

Family Hubs Support (Please check **one box** only)			
Infant-feeding support	☐		☐
Parenting programmes/parenting support	☐		☐
Perinatal mental health support	☐		☐
Parent-Infant relationship support	☐		☐
Speech and language and communication	☐		☐
One-to-one support for young people	☐		☐
Emotional support for child	☐		☐
Financial support	☐		☐
Homelessness	☐		☐
School readiness	☐		☐
Healthy start and free vitamins	☐		☐
Oral Health	☐		☐
Other – please outline:			☐

Briefly outline what support is needed e.g., information, advice, guidance, type of Service / Programmes requested:

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Confirmation of Consent: PLEASE READ CAREFULLY THROUGH COMPLETED FORM BELOW BEFORE SIGNING	
• I have read and understood the Family Hub Information Leaflet. • I consent to myself/my family/my child (delete as appropriate) being referred to the Family Hub and on to an appropriate service provider. • I understand and agree with the information provided and the referral to the Family Hub. • I understand that a further needs assessment may be required in consultation with myself to identify the service(s) required. • I understand that to access an appropriate service, there will be a need to share information about myself or my family with Hub Members. However, this will be on an agreed 'need to know' basis. *Signed (Parent/Person with Parental Responsibility/Individual) Date:…….. ***Referral Forms will only be accepted with either signature or dated confirmation that verbal consent has been given.**	
Signed:…… (Referrer)	Date:……
I confirm that verbal consent was provided by (parents) on this (date)	
Internal use only:	
• Date request for support received _____ • Date referral is processed, and support allocated _____	

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