**GUIDANCE NOTES FOR PARENTS / CARERS / SOCIAL WORKERS**

**Eligibility Criteria**

Buddies is organised into six-week blocks for up to 10 young people to attend on a rotation-based system (six-week in/ six-week off). Opening times or Saturdays 10am to 3pm, 49 weeks per year.

Young people who are not accessing any other services are our priority. The service is for young people aged 8 to 18, who have severe learning difficulties and behaviour that challenges. GCA scores are not considered in the criteria as each young person is individual and will need to be assessed accordingly.

Their compatibility with rest of group by age and abilities, which may determine which six-week block, they can attend.

Parental permission will need to be obtained before making a referral. Data consent to be signed by Parent/Guardian

Buddies is a Care inspectorate Wales registered provision (CIS) and has met full compliances since registering in 2017. The full inspection report can be found on CIW website <https://gov.wales/docs/cssiw/report/inspection_reports/00007763_c_171121_e.pdf>

The referral form provided should be completed in full and returned to: -

**Amanda Lervy – Director of Operational Services**

**250 Carmarthen Rd Swansea SA1 1HG**

[Amanda@localaid.co.uk](mailto:Amanda@localaid.co.uk)

Referrals will be acknowledged, and a visit will be arranged to meet with the family to assess their suitability to the project. If there is a waiting list, contact will be made when their name is nearing the top.

**Referral Form**

Young Person’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth\_\_\_\_\_\_\_\_\_\_\_ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Name/s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_ GP Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_

Families referred method of communication Email □ Telephone □ Text □ Post □

Are the family currently accessing a respite service? Yes No

If yes, please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Objective** What are the reason/s for the referral? (please underline)

To improve: Or:

Social skills/group interaction  Prevention of other interventions

Communication Skills to reduce risk of family breakdown

Access to leisure opportunities to provide respite

Independence/life skills

**Supporting Information (**please fill in with as much detail as possible)

1.Diagnosis / Emerging needs

2. Behaviours that may challenge

3 Parent / Sibling Information

4 Additional relevant information

**Support Needs**

staffing levels, what is needed to keep young person safe

Referral request from:

Parents School Social Worker Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT PERSONAL DATA**

I understand that the personal information collected by Local Aid will be held on file at the office & only shared with professionals from City and County of Swansea who are our main funders but will not passed on to any other parties without my prior consent. I understand that any information shared will be the minimum necessary for the senior manager to proceed to assessment stage.

I understand that this information will be held in accordance with the General Data Protection Regulations (GDPR) for a period of 7 years prior to completion of project/activity. I understand I have a right under the new GDPR to have access to all information held by Local Aid on request and that I also have the right for all my data to be forgotten.

**PARENT /CARER Print Name** ………………………………….. **Signed** ……………..…………………… **Date………..…….**

**The referral form provided should be completed in full and returned to: -**

**Amanda Lervy – Director of Operational Services**

**250 Carmarthen Rd Swansea SA1 1HG**

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