



## Settled Housing Support

Email: [shsreferrals@weareac.org](mailto:shsreferrals@weareac.org)

### Who We Are

Aberdeen Cyrenians gather and process your personal information in accordance with this [privacy notice](#) and in compliance with the relevant data protection regulation and laws. This notice provides you with the necessary information regarding your rights and our obligations, and explains how, why, and when we process your personal data.

We do not share or disclose any of your personal information without your consent, other than for the purposes of specified in our service user privacy notice or where there is a legal obligation to do so.

Aberdeen Cyrenians registered office is at 32 Scotstown Road, Bridge of Don, AB23 8HG and are a company registered in Scotland under company number SC070903. We are registered on the Information Commissioner's Office Register of Data Controllers under registration number Z5986517.

**Please complete the referral form, sign and date.**

**When we receive your completed referral , a member of the team will be in contact with you on the number and/or email you have provided. We aim to do this within 3 working days. Thank you.**

Name	
Preferred name	
Date of Birth	
Gender ID	
Preferred pronouns	
Address   Postcode	
Phone Number	
Email address	
Preferred initial contact method	Phone call <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/>
NI Number <i>or</i> Biometric Card ID	
Nationality	

<b>Are you :</b>	
Employed	<input type="checkbox"/> Yes <input type="checkbox"/> No
DWP	<input type="checkbox"/> Universal Credit <input type="checkbox"/> ESA <input type="checkbox"/> PIP <input type="checkbox"/> ADP <input type="checkbox"/> Pension
No Recourse to Public Funds	<input type="checkbox"/>
A Student	<input type="checkbox"/> Yes <input type="checkbox"/> No
A Veteran	<input type="checkbox"/> Yes <input type="checkbox"/> No
A Care Leaver	<input type="checkbox"/> Yes <input type="checkbox"/> No



<b>Housing Type</b>	<input type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Private <input type="checkbox"/> Housing Association <input type="checkbox"/> Homeowner
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**Housing Situation- please mark any of the boxes that you that relate to your needs:**

<input type="checkbox"/> Homelessness	<input type="checkbox"/> Risk of Homelessness	<input type="checkbox"/> Living with family or friends
<input type="checkbox"/> Rough Sleeping	<input type="checkbox"/> Living in unsuitable accommodation	<input type="checkbox"/> Difficulty accessing mainstream accommodation

**Please give support details of the areas you have marked, and any others not listed:**

**Support needs- please mark any of the boxes that relate to your needs:**

<input type="checkbox"/> Mental Health	<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Drug Use	<input type="checkbox"/> Physical Health
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Neurodivergence	<input type="checkbox"/> Abuse- current risk of harm and abuse of any form	<input type="checkbox"/> Finance   Budgeting
<input type="checkbox"/> Literacy	<input type="checkbox"/> Digital-awareness, learning, access	<input type="checkbox"/> Offending Behaviour	<input type="checkbox"/> Education/training/Employment

**Please give details of the support needs you have marked, and any other areas not listed:**



Do you have support in place from any other professionals or agencies e.g. Social Work, CPN, other organisation	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please detail below	

Emergency Contact   Next of Kin ( only used with your consent or where there is a risk to your immediate safety or others)	
Name	
Relationship to you	
Telephone Number	

If there is any additional information you would like to add to this referral, please use the box below:	
Date	
Your signature	

If this is not a self-referral, please record :	
Referrer's Name	
Relationship to Service User	
Telephone Number	
Email address	