

Short Term Independent Advocacy

To provide an independent accessible free advocacy service for people with learning disabilities, high functioning autism, aspergers, or mental health conditions.

Our advocates will enable those who are vulnerable or need help to make informed decisions and secure the rights and services they are entitled to. Advocates will work in partnership with the people they support and take their side.

Criteria:

Be aged 18+

Person must live in the Swindon area

And has one or more of the following:

Does not have any appropriate support, e.g. paid staff, conflict with family

No choice and control in their life

Not accessing the community

A threat to their health and well-being

Advocates can signpost people who do not meet the criteria by referring them for an assessment or diagnosis assessment, or to other services and or organisations.

If the person meets the above criteria we will offer a short – term, one off involvement, dealing with a specific issue in a person's life and does not involve a long term commitment. Advocacy relationships focus on resolving specific issues, will be time limited and come to an end when targets are met.

We anticipate that there will be a high demand for this service. We may not have capacity to meet all need. We will prioritise those in crisis, those whose independence is threatened, or people facing significant change in their lives.



Swindon Advocacy Movement
 Sanford House
 Sanford Street
 Swindon
 SN1 1HE
 Telephone on 01793 542575/616562
 Fax Number 01793 423124

SHORT TERM INDEPENDENT ADVOCACY

Client Details					
Name:					
Date of Birth:					
Address:	Accommodation Type:				
	Home Owner				
	Living with Family				
	Social Housing Tenant/Council House				
	Private Tenant				
	Supported Housing				
	Hostel				
	Hospital				
Other					
G P Name:	Current location of client (if not at home address)				
Address:					
Telephone Number:					
Children under 18:	Yes:		No:		
	Number:				
Carer:	Yes:	No:	Do they have a Family Carer:	Yes:	No:
Personal Budget:	Yes:	No:	In Receipt of Benefits	Yes:	No:
Referred By:				Position:	
Telephone Number:				Email:	
Agency:					
Other People involved in clients life:					
What is the best way for us to contact the client?					
Has this person agreed for this referral to be made				Yes:	No:

Advocacy

Advocacy is taking action to help people say what they want, secure their rights, represent their interest and obtain services they need.

Advocates are instructed or directed by the person at all times. Advocates don't do things or talk to people without their partners consent and they don't withhold information that other have shared.

This service is a short-term, one off involvement, dealing with a specific issue in a person's life and does not involve a long term commitment. This service is time limited and will come to an end when targets are met.

Please see criteria to access this service. An initial assessment appointment will be made to establish advocacy need. Please detail the specific issue where there is an advocacy need.

Examples of Advocacy outcomes

Access and or understand information,

Understand/exercise a right

Consider options/made a decision

Have a voice in a statutory or general life issue, access services.

Challenge a decision or make a complaint.

Risk Assessment:
This section needs to be completed in order for us to provide a service to the client. Please indicate below anything in the client's history or health needs which may give rise to potential risks or dangers either to themselves or to others. Please be aware, advocates are lone workers who often visit clients at home.
Any known mental health issues:
Any behaviours we need to know about:
Any known risks in lone working/visiting at home i.e. friends, family, history etc:
Any particular health needs i.e. Epilepsy, Asthma etc:
Any particular communication needs:
Any other details we need to be aware of:

Here at SAM we take your privacy seriously and will only use your personal information to provide you with independent advocacy in accordance with the General Data Protection Regulations.
 All information provided on the referral form and in any further dealings with Swindon Advocacy Movement will be treated as confidential and will not be disclosed to any third party without your express consent. Please see our Privacy Notice on request or on our website.

Please tick here if you would like to go on our mailing list for AGM etc

Signed (Client) _____ Date _____

Signed (Referrer) _____ Date _____

“Swindon Advocacy Movement is committed to safeguarding and promoting the welfare of children, young people and adults. Swindon Advocacy Movement expects all staff and volunteers to share that commitment”

Please send the above referral to:

**Swindon Advocacy Movement
 Swindon Advice and Support Centre
 Sanford House
 Sanford Street
 Swindon
 SN1 1HE**

**Telephone Number 01793 542575/616562, Fax 01793 423124
 Email: info@swindonadvocacy.org.uk (please send password protected)**



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EQUAL OPPORTUNITY MONITORING FORM

Swindon Advocacy Movement is committed to managing diversity and ensuring equality of opportunity for all. We will treat all cases fairly and equally in all aspects of their race, disability, gender, age, religion or belief, sexual orientation, marital status, pregnancy, maternity and sex.

In order to ensure the continued development of our Equal Opportunities and Diversity Policy all Clients are asked to complete the details below. The information will be used solely for monitoring purposes and will be treated as confidential.

Client Details										
Are you Married or in a Civil Partnership					Yes		No		Prefer not to say	
Gender:	Male		Female		Transgender		Prefer not to say			
Sexual Orientation:	Heterosexual		Gay man	Gay woman/ Lesbian		Bisexual		Prefer not to say		
Religion:	Christian		Muslim		None		Buddist		Jewish	
	Sikh		Hindu		Other (please state)		Prefer not to say			
Employment Status:	Employed		Unemployed		Registered Disabled		Retired		Student	Prefer not to say
Age Groups	Under 16	16-24	25-34	35-44	45-54	55-64	65+		Prefer not to say	
Post Code:					Prefer not to say					
Ethnicity:										
White British			Asian – British or Indian							
White Irish			Asian – British or Pakistani							
White Other			Asian – British or Bangladeshi							
Please specify;			Any other Asian background							
Mixed – White & Black Caribbean			Black – British or Black Caribbean							
Mixed – White & Black African			Black – British or Black African							
Mixed –White & Asian			Other Black							
Mixed – White Other			Oriental - Chinese							
Any other mixed background			Oriental – Other							
Prefer not to say			Not Established							
Disability:										
Do you consider yourself to have any long-standing illness or disability that affects your daily activities or the work that you do? Please tick										
Yes		No			Prefer not to say					
If you have answered yes to the question above, how would you best describe your disability. Please tick all that apply										
Hearing	Speech		Physical		Mental Health					
Visual	Mobility		Learning		Other					