Manawa Ora
Healthy Home Initiative

Referral form

Child's first name………………………………………………… **Guardian's** first name……………………………………

Child's last name………………………………………………… Last name……………………………………………………

Child's NHI…………………DOB……………………Gender……. Phone number…………………………………………………

Address……………………………………………………………… Mobile number………………………………………………

……………………………………………………………………… Alternative contact person: ……………………………

Phone number: ……………………………………………………

Child's ethnicity: ☐ Māori ☐ New Zealand European ☐ Pacific Islander ☐ Other

Language preference (please tick)? English ☐ Other (please specify)…………………………………………

How many people usually live in the home?.............

How many bedrooms does the house have?.............

How many *children* usually live in the home?.............

Eligibility criteria – clients must meet the following three criteria:

(a) Live in the Northland DHB catchment area (from Te Hana in the south to Cape Reinga): Yes ☐

(b) Residency status (please tick one): New Zealand citizen ☐ New Zealand permanent resident ☐

(c) Have a Community Services Card (CSC): Yes ☐

– OR are eligible for one, using the CSC income thresholds below: Yes ☐

Family of 2: $50 673

Family of 3: $61 224

Family of 4: $69 616

Family of 5: $77 835

Family of 6: $87 020

(For families of more than 6, the limit goes up another $8095 for each extra person)

('Family of' means total number of people living in the home. This is not based on age or parental status. So a 'family of 4' could be two adults and two children, or one adult and three children, for example.)

	Only one of the following are required	Yes Please tick
1	Is the client aged from **0 to 5 years** and hospitalised within the last 12 months – *or is at risk of hospitalisation due to their housing conditions* – with one of the following indicator conditions: LRTI, pneumonia, bronchiectasis, bronchiolitis, meningitis, TB, GAS sepsis, meningococcal disease, positive strep GN, Rheumatic Fever?	
2	Does the family have a child aged 0 up to 5yrs with at least two of the following social risks: finding of neglect or abuse by Oranga Tamariki—Ministry for Children, caregiver of child with a corrections history, long term benefit receipt, or mother has no formal qualifications – evidence not required	
3	Is the client pregnant, or has a baby up to six months of age?	

OR if your client meets one of the following criteria (questions 4 – 6), they must also answer yes to questions 7 & 8 (report functional or structural household crowding and have an additional child aged 0 –19 living with them).		
4	Is the client receiving monthly Bicillin Injections for Rheumatic Fever?	
5	Has there been 3 positive Strep A results from the household in *any* three month period? (if yes please write dates below) (1)……………………… (2)……………………………… (3)………………………..	
6	Is the client aged from **0 up to 14 years of age** and recently hospitalised with one of the following indicator conditions: *(LRTI, pneumonia, bronchiectasis, bronchiolitis, meningitis, TB, GAS sepsis, meningococcal disease, positive strep GN, Rheumatic Fever)?*	
If you have ticked yes to one of the above (questions 5 – 8) then they must also answer yes to the two questions below		
7	Is the home cold and / or damp and the family sometimes sleep together in one room to keep warm? (=functional crowding) or are there too many people for number of bedrooms? (=structural crowding)	
8	Is there an additional child or young person aged 0 –19 living in the house?	

Property status – Do you (tick one):			
Own your home?		Rent privately?	
Live in a Housing NZ home?		Board with family?	
Other:			

Referrer details

Referrer's first name…………………………………………… Last name……………………………………………………

Phone number………………………………………………… Mobile number……………………………………………

Email…………………………………………………………... Hospital……………………………………………………

Service/team…………………………………………………Date of referral………………………………………………

☐ I would like to discuss this referral with Manawa Ora. If yes, please give details:

………

☐ I would like to be informed of the outcome of this referral. If yes, please give details:

………

If you are unsure whether a family is eligible or not, please complete a referral form, and the Manawa Ora team will contact you for further information if required.

Email: manawaora@mahitahihauora.co.nz Fax: (09) 438 3210

Mark Trudinger (Regional Manawa Ora Coordinator) Phone: (09) 438 1015 or 021 415 665

Manawa Ora
Healthy Home Initiative

Informed consent form

I / We____

of

____
(address)

____
(address)

I am happy to be referred to the Manawa Ora Programme to see if there are any services that will help to improve my housing situation.

Yes / No (please circle).

I am happy for the Manawa Ora service and their contracted providers to share my information between and / or with any other agencies that can / will be able to help improve my housing conditions.

Yes / No (please circle).

I am happy to be contacted again to see if my health and my home conditions have changed.

Yes / No (please circle).

(NB: Parent, legal guardian, caregiver to sign if young person is under 16 years).

____Date_____________________
(Name) *(Signature)*