



# Immingham Access Point

*Working in partnership to make a difference*

## **AGENCY REFERRAL FORM** **FOR A DONATION FROM THE FOOD LARDER**

### **Section 1: General information about the Food Larder**

- 1) The Food Larder has been set up to help residents of Immingham and the surrounding villages who find themselves experiencing poverty, hardship and distress, despite a statutory system that in general supports them with their basic essential needs.
- 2) It exists to help those who experience **EMERGENCY** and **TEMPORARY FINANCIAL NEED**.
- 3) **When a person has no money for food because they have spent it on non-essential items, then it would be inappropriate for an agency, organisation or individual to make a referral to the Food Larder under such circumstances, without an identifiable programme of remedial action in place.**
- 4) Referrals must be made by completing a referral form. Self-referrals will be considered on an individual basis.
- 5) The food donations are accessed through the One Voice Immingham access point **12 – 3.30pm Monday Wednesdays and Fridays.**
- 6) The food will need to be collected in person by the applicant so their circumstances can be discussed further to ensure they have appropriate support to overcome the hardship they are facing. Please ensure you include an up-to-date contact number so we can arrange for them to collect the food parcel

**ALL SECTIONS OF THIS FORM MUST BE COMPLETED BY THE REFERRER**

### **Section 2: Referring Agency**

Date:  / /	Name of Agency:
Referrer's Name:	Position:
Referrer's Signature:	Contact Number:

### Section 3: Applicant/s Details

Full Name:	Address:
Date of Birth: ____/____/____	Postcode:  Contact number:
National Insurance No: ____-____-____-____	Spouse/Partner's Name:
Please tell us if you are in receipt of any benefits.	Spouse/Partner's Date of Birth: ____/____/____
When are benefits due again?  Date: ____/____/____	Spouse/Partner's National Insurance No: ____-____-____-____
How many people require this food:  Adults _____ Children _____	Please tell us the ages of the children.

## Section 4: Reason for the referral

Please give a detailed explanation regarding why they need a food parcel (it is not sufficient to state, for example, 'they have no money'):

What evidence has been seen that supports this applicant with regard to the reason given?

## Section 5: Any Special Dietary Requirements?

<p>Please list any requirements. (Whilst every effort will be made by us to take these into account, we are restricted by the type of foodstuff that is donated to us.)</p>			
<p>Does the applicant have access to the following cooking appliances</p> <p>Microwave <input type="checkbox"/>      Kettle <input type="checkbox"/>      Hob <input type="checkbox"/>      Oven <input type="checkbox"/></p>			

## Section 6: Support

Is the applicant known to you? Yes ☐ No ☐

Do they receive support from you? Yes ☐ No ☐

If **No**, are they receiving support elsewhere? Yes ☐ No ☐

If **Yes**, who from?

.....

If they are **not** receiving any support at present,  
do you (they) feel they could benefit from appropriate support? Yes ☐ No ☐

If **Yes**, in what areas?

.....

.....

...

.....

...

### Consent to share information:

\* I give my consent for information given on this form to be shared with others for the purpose of sign-posting to the appropriate agency/organisation in order to obtain the relevant support service for the area(s) detailed above.

\* I do not give my consent for information on this form to be shared with any third party.

*\* Delete as appropriate*

Signature of applicant: .....

Date: ...../...../.....

Please note: in certain cases it may be up to 24hrs from One Voice's receipt of this form before the food donation is available for collection.



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## Equal Opportunities Monitoring Form

We keep records of people who apply to us for support. This is to ensure that our service is provided on an equal basis without discrimination on the grounds of age, gender, race, ethnicity, sexuality, disability or religion. Any information you choose to give us will be treated in confidence and will be used for monitoring purposes only.

PLEASE TICK AS APPROPRIATE:				Male <input type="checkbox"/>		Female <input type="checkbox"/>		Postcode:	
AGE:	under18	18-24	25-29	30-34	35-39	40-49	50-59	60-69	70 +
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ETHNICITY:									
White	British <input type="checkbox"/>		Irish <input type="checkbox"/>		Any other White background <input type="checkbox"/>				
Black or British Black	African <input type="checkbox"/>		Caribbean <input type="checkbox"/>		Any other Black background <input type="checkbox"/>				
Asian or British Asian	Bangladeshi <input type="checkbox"/>		Indian <input type="checkbox"/>		Pakistani <input type="checkbox"/>		Any other Asian background <input type="checkbox"/>		
Mixed	White and Asian <input type="checkbox"/>		White and Black African <input type="checkbox"/>		White and Black Caribbean <input type="checkbox"/>		Any other Mixed background <input type="checkbox"/>		
Chinese or other ethnic group	Chinese <input type="checkbox"/>		Arab <input type="checkbox"/>		Other – please detail				
Traveller <input type="checkbox"/>	Gypsy <input type="checkbox"/>		Romany <input type="checkbox"/>		Irish Traveller <input type="checkbox"/>		Prefer not to say <input type="checkbox"/>		
SEXUAL ORIENTATION:									
Bisexual <input type="checkbox"/>	Gay <input type="checkbox"/>		Heterosexual <input type="checkbox"/>		Lesbian <input type="checkbox"/>		Prefer not to say <input type="checkbox"/>		
DISABILITY:									
Yes <input type="checkbox"/>	No <input type="checkbox"/>		Don't know <input type="checkbox"/>		If yes, please tick relevant box below:				
Mobility <input type="checkbox"/>	Visual Impairment <input type="checkbox"/>		Hearing Impairment <input type="checkbox"/>		Mental Health condition <input type="checkbox"/>				
Autistic Spectrum Condition <input type="checkbox"/>	Learning disability/difficulty <input type="checkbox"/>		Progressive Disability /Chronic Illness (e.g. MS, Cancer) <input type="checkbox"/>		Other - please detail				
RELIGION:									
Buddhist <input type="checkbox"/>	Hindu <input type="checkbox"/>		Sikh <input type="checkbox"/>		Muslim <input type="checkbox"/>				
Jewish <input type="checkbox"/>	Christian <input type="checkbox"/>		None <input type="checkbox"/>		Prefer not to say <input type="checkbox"/>		Not known <input type="checkbox"/>		Other – please detail

Thank you for taking the time to provide this information.