The Youth Disability Project currently provides youth services to young people who have a disability, are on the autistic spectrum or who have an emotional/behavioural need. The Project runs weekly clubs for the varying ages and abilities, as well as holiday schemes. The Project is specifically for young people aged 8-18, and up to the age of 25 in some clubs. We operate throughout the year, closing only for bank holidays, and the Christmas holiday period.

The project currently works with children and young people who are known to Children With Disabilities (CWD), Children who are Looked After, those Leaving Care (CLA), those under a Child Protection Plan (CP) and those who are a Child In Need (CIN), as we as those who are Transitioning to Adulthood. We are also open to self-referrals, referrals from parents, SEND and mainstream schools, colleges, and a large number may not be known to other services but may be in need of access to positive activities.

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| --- | --- | --- | --- |
| **Child/Young Person’s Details** | | | |
| Name: |  | | |
| Date of Birth: |  | CSC/LAS-Liquid logic – identification number/case no. |  |
| Address: |  | Postcode: |  |
| Phone numbers |  | School/college |  |
| Is the child in receipt of Free School Meals? |  | | |
| **Contact Details** | | | |
| Name of Contact |  | Relationship to Young person |  |
| Phone numbers |  | Email |  |
| **Social worker details** | | | |
| Name of social worker |  | Phone number |  |
| SW-Email |  | Team name-  i.e-CWD/Early Help |  |
| **Referrer Details** | | | |
| Name |  | Date |  |
| Agency/ relationship |  | Address |  |
| Telephone |  | Email |  |
| Is the child/young person aware of the referral? | Yes/No | Does the child/young person consent? | Yes/No |
| If unable to consent, does the parent/carer, social worker, educational staff consent in the child/yp’s best interests? | | | Yes/No |
| **Reason for referral**  Briefly describe the reason for the referral into the youth project and outcomes you hope will be met for the child/young person. | | | |
|  | | | |
| Other information- is this a referral for after school club/ evening youth club or holiday schemes? Or both - please specify | | | |
|  | | | |
| What is the child/yp’s disability/ condition/ needs (including behaviours that challenge/absconding concerns) |  | | |
| Is the child’s needs classed as-**Profound, Severe, Moderate or Mild?** |  | | |
| Do they have any medical needs? |  | | |
| Do they require 1:1 support? |  | | |
| Do they have a social care package? If yes please define existing support in place. |  | | |
| Do they require personal care? |  | | |
| Any other relevant information. |  | | |

When completed please return to: [CYDP@croydon.gov.uk](mailto:CYDP@croydon.gov.uk) inbox monitored Monday-Wednesday The referral will be considered on the basis of whether we can meet the needs of the child/young person within our settings in a safe way and meeting a duty of care.