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) The parents/caregivers/family (not just the child) have a Community Services Card (CSC): Yes ☐

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

Family of 2: $54 098

Family of 3: $66 589

Family of 4: $76 822

Family of 5: $86 873

Family of 6: $97 937

(For families of more than 6, the limit goes up another $9926 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 **under 5 years old** 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 under 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 under 19 years old 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 **under 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 4 – 6) 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 under19 years old living in the house?	

Property status – Do you (tick one):			
Own your home?		Rent privately?	
Live in a whānau-owned home?		Live in a Kāinga Ora (previously HNZ) home?	
Other:			

Referrer details

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

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

Email……………………………………………………..……….. Organisation………………………………………………

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

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.

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

I am happy for Manawa Ora to access my child's medical records if necessary, to check if they are eligible for services which may improve our health and housing conditions.

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

(Name) *(Signature)*
____Date____________________