Membership and Needs Assessment Policy

What do we mean by Needs Assessment?

Deafblind Scotland carries out a needs assessment in order to offer access to appropriate programmes and/or services to deafblind people or people with single sensory impairment and at risk of progressive second sensory impairment whether that is a sight or hearing loss. Deafblind people may also have their needs assessed as part of the procedure involved in being offered full membership of Deafblind Scotland. People with single sensory impairment and at risk of progressive second sensory impairment whether that is a sight or hearing loss will be offered associate membership.

Policy Statement

Deafblind Scotland seeks to provide a guide/communicator service to deafblind people as part of a whole range of services which may improve their quality of life. People with single sensory impairment and at risk of progressive second sensory impairment whether that is a sight or hearing loss will be offered access to appropriate programmes and/or services. In order to do this Deafblind Scotland will carry out a straightforward assessment of need which will include both needs as stated by the individual and also those observed by the qualified member of staff who undertakes the assessment.

Where needs are noted during the assessment for membership, the agreement of the individual will be secured before these needs are notified to any appropriate agency. Where possible the potential member will be made aware of other available statutory and voluntary services and the pathway to accessing these services. This will include Deafblind Scotland projects which may include the provision of a guide/communicator service within medical settings, health improvement activities, quality of life activities, etc. Further assessment for membership will include supporting those who have a single sensory impairment and are at risk or progressive second sensory impairment whether that is a sight or hearing loss.

Where needs are noted during an assessment to receive a contracted guide/communicator service then the terms of the agreement under which the service is offered will be adhered to, in which case the individual user will be informed of these.

Definition of Deafblindness

To be assessed for membership of Deafblind Scotland there is a particular focus on people who are dual sensory impaired, that is both a severe sight and hearing loss.

To be assessed for a guide/communicator service the following needs of the person will be specifically considered:

- Communication
- Mobility problems
- Health issues
- Mental health issues

- Family support available
- Community support available
- Statutory support available
- Housing support needs
- Shopping support needs
- Independent living support needs
- Social support needs
- Involvement in their community
- Interests and hobbies

Relevant forms will be completed to ensure this information is captured and recorded. Relevant agencies will be informed where the individual has agreed to this or contracted service requires the reporting of need.

Deafblind Scotland will report to the individual when information has been forwarded to other agencies (in compliance with GDPR 2015)

Deafblind Scotland will monitor the response of other agencies to any need reported by Deafblind Scotland.

Deafblind Scotland's staff will include this assessment of need in the service-user's file and ensure any necessary Risk Assessment is undertaken, any identified risks are minimised and control measures implemented.

An assessment of need will be undertaken on request from the individual deafblind person, family members, carers, a statutory agency, voluntary agency, funding agency, Deafblind Scotland projects.

Appendix 1 – Needs Assessment Flow Chart procedure.
Appendix 2 – Hard & See Hear Leaflet.

Assessment/Membership Report

(Please delete if not applicable)

Surname:		Mr/Mrs/Miss/Ms	
First Name(s):			
Address:			
Local Authority:		**Postcode:**	
Date of Birth:			
Telephone No:		**Emergency No:**	
Doctor:		**Surgery & Tel:**	
Email address:			
Reason for Ref:		**Date of Referral:**	
Referrers Name			
Assess date:		**Assessed by:**	

How would you describe yourself (tick box)?

Asian ❑ **White** ❑

Africa/Caribbean ❑ **Other** ❑

Tell us about your work:

Do you have a job? **Yes** ❑ **No** ❑

If yes, what is your job?

____

If no, when did you last work and what was your job?

____

The above-named person is dual sensory impaired due to:

Visual Impairment Cause:	
Reg blind: or **Partially sighted:**	Please state which one and give registration number.
At what age when you began to lose your vision:	Please insert the age they were when they began to lose vision
Hearing Impairment Cause:	

How old were you when you began to lose your hearing:	
Last Hearing Check:	Date:
Last Vision Check:	Date:
Do you have Ushers:	

Have you had any retraining since you became deafblind? **Yes** ❑ **No** ❑

If yes, please describe ____

OR

The above-named person is single impaired:

SIVI ❑	**SIHI** ❑

Communication Information: (delete as appropriate)

Hearing Aid:	Yes/No	Sign Language Used:	Yes/No
Spectacles:	Yes/No	Other Aid: (specify):	
Preferred Language:		Interpreter:	Yes/No
Hear speech:	Yes/No	Do you use speech:	Yes/No
DBM/fingerspelling:	Yes/No	Block letters:	Yes/No
Hand on Signing:	Yes/No	Lip read:	Yes/No
Large writing on paper:	Yes/No		

Tell us about how you read:

Can you read Braille: Yes/No
Can you read Moon: Yes/No
Can you read normal print: Yes/No
Can you read large print like this: Yes/No
Can you read extra large print Yes/No
Can you read XXLP Yes/No
Can you read XXXLP Yes/No

Which method would you prefer to receive mail, one of the above or CD or Email,

please circle which method above you would like:

Any relevant information which affects your well being: (include relevant medical information) e.g.

Mobility:

Personal care/Domestic needs:

Mental well-being:

Social opportunities:

Description of Risk	Present	Comments
Moving & Assisting Service users	Yes / No	
Hygiene in Service Users Home	Yes / No	
Electrical Equipment	Yes / No	
Challenging Behaviours	Yes / No	
Animal risk	Yes / No	
Smoking / fire risks	Yes / No	
Substance misuse	Yes / No	
Other (specify)	Yes / No	

The above-named person would like DBS to write to the appropriate agencies to request the following equipment on their behalf:

Loop ❑	**Lighting** ❑
Door Access ❑	**Telephone** ❑
Other:	

Is this referral urgent: YES ❑ NO ❑

The above-named person would like DBS to write to Social Work to request the following training on their behalf:

Mobility/cane ❑	**Independent Living Skills** ❑
Home Orientation ❑	**Route Orientation** ❑
Communication Skills ❑	**Information Request** ❑
Other:	

What kind of support/help do you think you need (if any)?

Communicator/Guide ❑

Volunteer befriender ❑

Mobility training ❑

Communication training ❑

Home-help ❑

Advice ❑

Counselling ❑

Communicard ❑

Other, please describe ___________________________________

Would you like us to write to Social Work to request any of the above services (Funding may be required) YES ❑ NO ❑

Tell us about any help you are getting now. Who is your social worker or worker for the blind/deaf?

____

Which authority/organisation does the above person work for?

____

Are you already in contact with someone from Deafblind Scotland? Yes ❑ No ❑

What is their name?

____

Where do you live:

Alone	Yes / No
With relatives (if so who)	Yes / No
In Sheltered Housing	Yes / No
In a residential home	Yes / No
In a Nursing home	Yes / No
Other, please describe	

Do You receive benefits:

DLA/PIP – Care element	Yes / No
DLA/PIP – Mobility element	Yes / No
Attendance Allowance	Yes / No
Incapacity Benefit/ESA	Yes / No
Severe Disablement allowance	Yes / No
Unemployment Benefit	Yes / No
Other benefits:	

We can refer you to our Welfare Rights team.

Do you need help in applying for any benefits? Yes / No

If Yes, which benefit? ___________________________________

Have you ever been in the Armed Forces which includes National service? YES / NO Scottish War Blinded have lots to offer, including activities etc, regardless of when you became blind. If you would like to hear more about what they have to offer you can sign below and I can ask them to contact you:

____

Have you had a Home Fire Safety visit: Yes/No. If you would like us to arrange one for you pleased tick the box and I will ask them to contact you to arrange a visit:- ☐

Visit Report ____

Family Support: ______________________________________

____

____

How did you find out about Deafblind Scotland? If you picked up a 'Hard to see & Hear leaflet', where from?

____

What we will do now:

- **Write to Social Work if applicable:**
- **Refer to another organisation if applicable:**
- **Process the assessment:**
- **Write to you within 4 weeks:**

Please sign to give your permission for us to write to appropriate agencies on your behalf (if required) and that the above information is correct:

Signature______________________________

********** **MEMBERSHIP** **********

Membership is free to anyone who fits this definition:

"Persons are regarded as deafblind if they have a severe degree of combined visual and auditory impairment resulting in problems of communication, information and mobility."

I confirm that the information contained in this form is correct. I accept it will be shared with people within Deafblind Scotland. All information will remain strictly confidential in accordance with the Data Protection Act 1998.

If you would like to be a member of Deafblind Scotland and agree to the GDPR please sign here:

Signature________________________________

PLEASE COMPLETE THE GDPR FORM ON THE NEXT PAGE

General Opt In Declaration

Deafblind Scotland is committed to ensure that personal data will only be used for the purposes for which it was given and for which Deafblind Scotland has a lawful reason for processing, therefore we require you to opt in if you wish us to stay in touch. Please complete

1. **I am happy for Deafblind Scotland to securely hold my information for the purposes of communications. (Please tick)**

   Yes ☐ **No** ☐

2. **I am happy to receive newsletters, fundraising and marketing communications from Deafblind Scotland in the form of: (please tick)**

   E-mail ☐ **Post** ☐ **Telephone** ☐

3. **Information should be in; (please tick)**

   Braille ☐ **Moon** ☐ **Large Print** ☐ **XLP** ☐

   XXLP ☐ **XXXLP** ☐

   CD ☐ **Email** ☐

Other please Specify…………………………..

If you opt in we will check with you annually if you still consent to DbS contacting you. You can opt out at any time.