Smart Savings

Creative Pathways to Smart Money Project

Debt and Mental Health Evidence Form

For completion by a health care professional or support worker with their client. For your client to be eligible for the project, they must have a 'mild to moderate' mental health problem, and have money/debt issues.

Please sign and return the original form to: Jane Jiwa, Smart Savings, The Elms, 61 Green Lane, Redruth TR15 1LS.

If possible, also send a digital copy of this form to jane@smartsavings.org.uk.

If you need help with completing this form, call Jane Jiwa on 01209 212579.

COMIC RELIEF

This form was based on the DMHEF which was developed by the Money Advice Liaison Group and the Royal College of Psychiatrists - www.rcpsych.ac.uk/debt.

1. Do you struggle with a mental health condition? (E.g. anxiety, depression, mild OCD, mild PTSD, or mild panic disorders)

2. Can you please describe your problems with money management? Can you estimate the size of your debts?

3. Has your mental health condition been diagnosed by a GP/ mental health professional? If yes, what is the diagnosis? If no, please describe the mental health condition.

Notes for question 3: If there is more than one diagnosis, please detail.

4. Can you explain how your mental health condition affects your ability to deal with money? (E.g. communication or concentrate difficulties, or receives assistance with money management from another person such as someone with power of attorney, or another third party).

5. Can you tell me how long you've had this mental health condition, and how often it occurs? (E.g. one onset or multiple times.)

6. Are you receiving treatment or support for your mental health condition? (Yes or No)

7. Can you explain the support or treatment you have received in the past and present, and how this affects your ability to deal with money?

Notes for question 7: Please provide examples (**what medication are you taking and are there any side-effects** e.g. the person may have memory or concentration difficulties; or the individual is often away from home whilst being cared for as a hospital in-patient, which makes it difficult to manage finances). How often do you need to take the medication?

8. Does your mental health condition affect your everyday life? (E.g. can't get up in the morning, can't get out of the house, or panic in groups? Please explain.)

Notes for question 8:

Please provide examples in non-clinical language (e.g. cannot leave their home; has difficulty in understanding information/making decisions)

Will you be able to attend regular group sessions in art therapy, horticulture and cooking? We need to find out if anything gets in the way of the person going out.

9. Do you have any difficulties with communication due to your mental health condition? What difficulties do you have? Do you have difficulties in being contacted by telephone, letter, or in person? Which is the best method?

10. Is the person aware you are making this referral, and the information contained in this form? (Yes or No)

Notes for question 10: The person named on this form may wish to see the information that has been collected about them. However, if seeing this information could (a) result in serious physical or mental harm to the named person or (b) to others, then please tick the 'No' box opposite.

Does this person present a risk to others, from others, or towards self?

Additional notes:

About you

Your contact details as the health care professional or support worker

Your name:

Your address:

Your telephone number: Your mobile number:

Your email address:

Your relationship with the person named on this form:

- ☐ Social Worker
- ☐ Clinical Psychologist
- ☐ General Practitioner
- ☐ Mental Health Nurse
- ☐ Psychiatrist
- ☐ Occupational Therapist

Other (please specify) ____________________

☐ Tick here if you are also the Care Coordinator

Finally

Please sign and date this form

We greatly appreciate your assistance in completing this form.

Signature:

Date:

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Client Consent Form

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About the person

QUESTION 1

Does the person have a mental health problem?

Yes No

QUESTION 2

Does the person have a mental health problem that currently affects their ability to deal with money?

Yes No

Does this mental health problem have a name?

Please provide the main diagnosis in plain English.

For completion by the client.

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Jane Jiwa, Smart Savings, The Elms, 61 Green Lane, Redruth TR15 1LS.

If possible, also send a scanned digital copy of this form to jane@smartsavings.org.uk.

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Client Consent Form

Your details as the client

Your name:

Your address:

Your telephone number:

Your mobile number:

Your email:

Your consent – please sign

I authorise my health care professional or support worker to provide information about my health to Smart Savings South West CIC by completing the Debt and Mental Health Evidence Form.

I authorise Smart Savings South West CIC to exchange information about my health and well- being where needed amongst the Smart Savings team and with any other interested parties involved in my care, including my G.P.

I authorise Smart Savings South West CIC to store information about me on the basis that (a) this information will be securely stored and (b) will be destroyed when it is no longer relevant.

I authorise Smart Savings South West CIC to share information about my health and debts with relevant creditors (including their agents) to improve their understanding of my health and debt situation.

Signature: Date: