Supported Living Program

Referral / Application form

How this application/ Referral form used?

- This form is to be completed in consultation with the person with disability (with NDIS plan or expecting an NDIS plan for Supported Independent Living) and their family/carer/guardian/advocate/decision maker and decision support (e.g. case manager or support planner) in regards to accommodation support options.
- For example- If a person requires supervision and support to help maintain their independence, supported independent living (24/7 staff support) included in NDIS Plan may be suitable. If a person requires continuous supervision and support, a 24/7 group accommodation placement may be more suitable.
- To ensure the best possible outcome for the person seeking accommodation support, please ensure the information is detailed, accurate and current.
- Send copies of ***Relapse Prevention Plan*** *(completed by a Clinician)* **NDIS Plan** along with this referral/ application form.
- The person with disability, family/carer/guardian/decision maker for the person and the decision support must all agree that the request for accommodation support is appropriate.

Checklist:

- ☐ Completed referral form
- ☐ Relapse Prevention Plan completed by Clinician
- ☐ Copy of NDIS Plan

Competed referral form and relevant documents please forward to info@greenleafcareplus.com or more information don't hesitate to contact **Joby on 0452 588 490**

PARTICIPANT'S PERSONAL DETAILS:			
Name		Date of Birth	
NDIS Number		NDIS Plan Date	
Gender	Male ☐ Female ☐	Date of Referral	
Primary Disability		Other disability	
Does this Participant have a carer?	Yes ☐ No ☐ If Yes: Formal ☐ Informal ☐	Name & address of Carer: Contact Number: Relationship:	
Does this Participant have a Legal Guardian?	Yes ☐ No ☐	Name & address of Guardian: Contact Number:	
Does this Participant have a Public Advocate?	Yes ☐ No ☐	Name & address of Advocate: Contact Number:	
Indigenous status	Yes ☐ No ☐	Indigenous identity	○ Aboriginal
Ethnic Origin			○ Both Aboriginal & Torres Strait Islander
Interpreter required	Yes ☐ No ☐ Country of birth		Preferred language
Current Address		Suburb	
Post code		Mobile	
Daytime phone		Email	

Does this person provide consent to make referral/ share his personal information for his wellbeing?

Yes ○ No ○

PRIMARY CONTACT (if different to the above):		PERSON COMPLETING THIS FORM (Referrer):	
Name		Name	
Relationship to person requiring support		Relationship to person requiring support	
Phone		Phone	
E-mail		E-mail	
Address		Address	
Organisation (if applicable)		Organisation (if applicable)	

UNDERSTANDING PARTICIPANT'S CURRENT ACCOMMODATION & LIVING ARRANGEMENT:					
Please tick one box below to tell us where this person currently live.					
Family home	○	Own home (Private residence)	○	Hospital (Rehab ward)	○
Mental health facility (eg: AMHU/ ASUSD/BHRC)	○	Group home	○	Other (Specify)	
When this Participant required supported accommodation?			Expected date:		
Participant required supported accommodation (24/7 staff support), Why?					

MEDICATION MANAGEMENT *(In SLP medication must be kept in office and monitor by staff member)*:	
List of Medication:	
Allergies:	
Current medication setup	
Adherence issues:	

HEALTH CONDITIONS:	
Mental Health Diagnosis:	Primary: Secondary:
Physical Illness:	
History of Epilepsy?	Yes ◯ No ◯ If Yes, when was the last episode?

MAINSTREAM SERVICES/ CORRECTIONAL SERVICES:		
Service Type	**Yes / No**	**Name & Contact details:**
GP	◯ Yes ◯ No	
Clinical Manager	◯ Yes ◯ No	
Psychiatrist	◯ Yes ◯ No	
Psychologist	◯ Yes ◯ No	
Dentist	◯ Yes ◯ No	

Chiropodist	◯ Yes ◯ No	
Probation & Parole	◯ Yes ◯ No	
AOD	◯ Yes ◯ No	
Any Others (Please specify):	◯ Yes ◯ No	

LEGAL MATTERS (Please tick applicable and more details):	
Mental Health Orders (eg: PTO)	
Order relating to children	
Intervention Orders	
Guardianship or Administration Orders	
Any other Orders	

OTHER SERVICES/ PROVIDERS INVOLVED:		
Organisation/ Provider	**Service Type**	**Contact person & details**

EMERGENCY CONTACT:

Family Member/ Next of Kin (Name , Address & Contact Number)	
Relationship	

FINANCIAL MANAGEMENT:	
Who is managing this person's finance?	Self ◯ Public Trustee ◯
If this person have Public Trustee, please provide contact details	
Source of Income Fortnightly Income	☐ DSP ☐ Employment ☐ Other benefits or Income Fortnightly Income:
Centerlink Reference Number (CRN)	
Does this person require assistance with budgeting?	
Current Budget (Fortnightly): • Rent (including CRA) • Utilities (Electricity, Gas, Water) • Groceries	

HOSPITAL ADMISSIONS:	
How many hospital admissions have this person had in the past 2 years? And reason	
When was the last admission and how long this stay?	

RISK FACTORS:		
Current or history of Substance use	Yes ◯ No ◯	Details:
Current or history of Alcohol use	Yes ◯ No ◯	Details:
History of Suicidal risk	Attempts ☐ Thoughts ☐ Ideation ☐	Details:
History of Self harming	Yes ◯ No ◯	Details:
Aggressive behavior towards others	Yes ◯ No ◯	Details:

DAILY LIVING & COMMUNITY ACCESS:	
Any Special needs (eg: home modification, Mobility aids)	
Does this person require any assistance for personal care (specify prompting, physical assistance)	
Any continence issues	
History of falls	

How this person accessing the community?	
Does this person able to use public transport?	
Does this person require any assistance for shopping and to get appointments?	
Does this person able to cook his meals?	
Additional information:	

Please email completed form with any additional information to info@greenleafcareplus.com.
Please call 0452 588 490 (Joby) if you require assistance or further information

FOR GREENLEAF USE ONLY		
☐ **Eligible**	☐ **Accepted** ☐ **Waiting list**	
☐ **Not Eligible**	**Reason:**_____ ☐ **Referrer informed**	**Date:**