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| Accommodation Customer Referral Form Applies to: Aged and Disability Care | | | | | | |  | | |
| Purpose | This form is to be completed by the Customer Experience Manager when a new customer applies for SIL or SDA services. | | | | | | | | |
| Instructions | Please provide the information in each section below then email this form to intake@claro.com.au | | | | | | | | |
| **Form completed by** | | **Name** | Enter text | | | **Position** | | Enter text | |
| **Email** | Enter text | | | **Phone** | | Enter text | |
| Date of referral | | Enter text | | | | | | | |
| **Referrer name** | | Enter text | | | | **Position** | | Enter text | |
| **Organisation** | | Enter text | | | | | | | |
| **Email** | | Enter text | | | | **Phone** | | Enter text | |
| Customer Contact Details | | | | | | | | | |
| Customer Full Name | | Enter text | | | | | | | |
| Address | | Enter text | | | | | | | |
| State | | Enter text | | | **Postcode** | | | | Enter text |
| **Email** | | Enter text | | | **Phone** | | | | Enter text |
| **Date of birth** | | Enter text | | | **Gender identity** | | | | Enter text |
|  | | | | | | | | | |
| **Next of Kin (Full Name)** | | Enter text | | | **Relationship** | | | | Enter text |
| Address | | Enter text | | | | | | | |
| State | | Enter text | | | **Postcode** | | | | Enter text |
| **Email** | | Enter text | | | **Phone** | | | | Enter text |
|  | | | | | | | | | |
| **Funding body** | | | | Enter text | | | | | |
| **Claim or participant number**  *Please provide the funder’s customer identifier here - e.g.: for NDIS, provide the participant number; for TAC, provide the claim number and date of accident* | | | | Enter text | | | | | |
| **Funding contact** | | | | Enter text | | | | | |
| **Email** | Enter text | | | | **Phone** | | | | Enter text |

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| Customer information | | | | | | | | | | | | |
| **Diagnosis** | Enter text | | | | | | | | | | | |
| **Mobility** | Ambulant | | | | | | Walking stick | | | Walking frame | | |
| Manual wheelchair | | | | | | Power wheelchair | | | Other: Enter text | | |
| **Assistance required**  **Comments:** | Independent  1:1  2:1  Enter text | | | | |  | | | | | | |
| **Transfer equipment required** | Enter text | | | | | | | | | | | |
| **Does the customer take regular medication?** | Yes | | No | | | | **Comments** | | Enter text | | | |
| **Complex care requirements** | Enter text | | | | | | | | | | | |
| Support Worker Preferences | | | | | | | | | | | | |
| **Gender** | Enter text | | | **Age** | | | Enter text | | **Driver licence** | | Yes | No |
| **Language and Culture** | Enter text | | | | | | | | | | | |
| **Skills / Interests / Hobbies** | Enter text | | | | | | | | | | | |
| **Comments** | Enter text | | | | | | | | | | | |
| Social Situation | | | | | | | | | | | | |
| **Describe the customer’s social situation. Do they live alone?** | Yes | No | | | **Comments** | | | Enter text | | | | |
| Behaviour support | | | | | | | | | | | | |
| **Does the customer have a behaviour support plan?** | Yes  *Please attach a copy* | No | | | **Comments** | | | Enter text | | | | |
| Epilepsy management | | | | | | | | | | | | |
| **Does the customer have an epilepsy management plan?** | Yes | No | | | **Comments** | | | Enter text | | | | |
| **Diabetes** | | | | | | | | | | | | |
| **Does the customer have diabetes?** *If Yes, are we supporting the customer with their diabetes? Management plan required.* | Yes | No | | | **Comments** | | | Enter text | | | | |
| **Asthma** | | | | | | | | | | | | |
| **Does the customer have asthma?** *If Yes, an asthma management plan is required.* | Yes | No | | | **Comments** | | | Enter text | | | | |

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| Service | | | | | | | | | | | | | | |
| In home support | | | | | | | | | | | | | | |
| **Tasks** | 1. Personal care | | | 2. Therapy | | | 3. Domestic support | | | | | | 7 Other: | |
| 4. Meals | | | 5. Transport | | | 6.Community access | | | | | |  | |
|  | Morning | | | Afternoon | | Overnight | | | | Tasks *Please use numbering above* | | | | |
| Monday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| Tuesday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| Wednesday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| Thursday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| Friday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| Saturday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| Sunday | Enter text. | | | Enter text. | | Enter text. | | | | Enter text. | | | | |
| **Total rostered hours** | | | **Enter text.** | | | **Total approved hours/$** | | | | | | **Enter text.** | | |
| Accommodation | | | | | | | | | | | | | | |
| **Current living situation** | | Enter text | | | | | | | | | | | | |
| **Specific accommodation needs** | | Enter text | | | | | | | | | | | | |
| **Funding body** | | Enter text | | | | **Bed fee** | | Enter text | | | **Residential contribution** | | | Enter text |
| **Preferred area/ property** | | Enter text | | | | | | | | | | | | |
| **Housemate preferences** | | Enter text | | | | | | | | | | | | |
| **Independent Living Skills** | | ☐ Independent  ☐ Supervision Only  ☐ Verbal Prompts  ☐ Some Assistance  ☐ Full Assistance | | | | | | | | | | | | |
| **Which type of accommodation services is the person seeking?** | | | | | SIL – Supported independent living | | | | SDA – Supported disability accommodation | | | | | |
| **Does the person have an SIL funding assessment?** | | | | | Yes | | | | No | | | | | |
| **Does the person have an SDA funding assessment?** | | | | | Yes | | | | No | | | | | |
| **If the person has an SDA funding assessment, which design category has been approved or is likely to be approved?** | | | | | Improved liveability  Fully accessible  High physical support  Robust | | | | | | | | | |