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| Accommodation Customer Referral FormApplies 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[ ]  2:1Enter 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 |