**Thank you for considering Brighter Access for your future home.**

**Please complete the following information** (Type your responses at the yellow placeholders)

|  |
| --- |
| **General Information** |
| **Participant name**  |  | **Date of Referral** |  |
| **NDIS Participant No:** |  | **D.O.B.** |  |
| **Participant Contact No:**  |  |
| **Current Address** |  |
| **Cultural Requirements** |  |
| **Religion**  |  |
| **Gender**  | [ ]  Male [ ]  Female [ ]  Other [ ]  I do not wish to disclose this information |
| **Language**  | [ ]  English [ ]  Other (specify):  |
| **Communication method**  | [ ]  Verbal [ ]  Other (specify):  |
| **Who do you currently live with?** |  |
| **Where would you like to live?** |  |
| **When would you like to move?** |  |
| **I can share with the Opposite Gender** | [ ]  No [ ]  Yes Specify:  |

|  |  |
| --- | --- |
| **Health Map** | **Comments** |
| **Primary diagnosis** |  |  |
| **Other diagnoses****(Disability and Health)** |  |  |
| **High Intensity Personal Daily Activities**  | Complex Bowel Care[ ]  No [ ]  Yes  | Enteral Feeding[ ]  No [ ]  Yes  | Severe Dysphagia[ ]  No [ ]  Yes  | Urinary Catheter Support[ ]  No [ ]  Yes  |  |
| Subcutaneous Injections[ ]  No [ ]  Yes | Complex Wound Care [ ]  No [ ]  Yes | Ventilator Management (inc. CPAP) [ ]  No [ ]  Yes | Tracheostomy Support [ ]  No [ ]  Yes*:*  |  |
| **Sleeping routines**  |  |  |
| **Drug / alcohol / cigarette use history or present**  | [ ]  No [ ]  Yes  |  (specify)  |  (specify)  |  (specify) | **Supports currently in place:** |
|  |  |  |  |
| **Current health conditions**  |  |  |  |  |  |
| **Historical health conditions**  |  |  |  |  |  |

| **Circle of Support** | **Comments** |
| --- | --- |
| **Coordinator of Supports contact information** | Name  | Phone Number | Email | Postal Address |  |
|  |  |  |  |
| **Person Responsible Contact Information** | Name | Phone Number | Email | Postal Address |  |
|  |  |  |  |
| **Guardian Contact Information /****Function Details** | Name | Phone Number | Email | Postal Address |  |
|  |  |  |  |
| **Trustee and Guardian** | [ ]  No [ ]  Yes  | Phone Number | Email:  |  |
|  |
| **Family involvement**  | Relationship NamePhoneEmail | Relationship NamePhoneEmail | Relationship NamePhoneEmail | Relationship NamePhoneEmail |  |
| **Family Contact (Detail family visit information)** |  |  |
| **Work or Day Program Information** | Provider: |  | Provider: |  |  |
| Location: |  | Location: |  |
| Days:  |  | Days:  |  |
| Times: |  | Times: |  |

| **Support Needs** | **Comments** |
| --- | --- |
| **Behaviours of concern**  | I can be physically aggressive towards others[ ]  No [ ]  Yes  | I engage in physical aggression towards myself (Self-Harm)[ ]  No [ ]  Yes  | I can be physically aggressive towards property[ ]  No [ ]  Yes  | I can be verbally aggressive towards others[ ]  No [ ]  Yes  |  |
| I may abscond or accidentally walk off[ ]  No [ ]  Yes | I have sexualised behaviours [ ]  No [ ]  Yes | *Other*:  | *Other:*  |  |
| **Restrictive Practices Identified** | *Specify:*  | *Specify:*  | *Specify:*  | *Specify:*   |  |
| **Are RPA’s currently in place?** | [ ]  No [ ]  Yes | [ ]  No [ ]  Yes  | [ ]  No [ ]  Yes  | [ ]  No [ ]  Yes  |  |
| **Access / Mobility Requirements**  | I’m at risk of slip/trip/falls[ ]  No [ ]  Yes | I need support with manual handling at times[ ]  No [ ]  Yes | I use a manual wheelchair[ ]  No [ ]  Yes | I use an electric wheelchair[ ]  No [ ]  Yes |  |
| I use a walking frame[ ]  No [ ]  Yes | I can self-transfer to bed or vehicle[ ]  No [ ]  Yes | I need to use a hoist when transferring[ ]  No [ ]  Yes | I require bathroom modifications[ ]  No [ ]  Yes |  |
| I can walk without staff assistance (Independent)[ ]  No [ ]  Yes | I require staff assistance with walking: [ ]  Supervision [ ]  Standby assist [ ]  Minimal assist [ ]  Maximal assist | I can climb some stairs i.e., 2-3[ ]  No [ ]  Yes*Specify*:  |  |
| **Vehicle / Transport Requirements** | I can travel in a passenger car[ ]  No [ ]  Yes | I require a larger vehicle like a multi-passenger vehicle[ ]  No [ ]  Yes | I need a fold-down step or other vehicle modifications[ ]  No [ ]  Yes | I need a wheelchair accessible vehicle with a hoist[ ]  No [ ]  Yes |  *Other:*  |
|  | I require driver protection screen(like a taxi screen)[ ]  No [ ]  Yes | I use a harness or seatbelt guard[ ]  No [ ]  Yes | I can use public transport[ ]  No [ ]  Yes | I walk to the shops unassisted [ ]  No [ ]  Yes |  *Other:*  |
| **Daily Living Requirements** | I need staff support all the time[ ]  No [ ]  Yes | I need support with my health conditions e.g., epilepsy/diabetes/bolus feeds [ ]  No [ ]  Yes | I need support to take my regular medication[ ]  No [ ]  Yes | I can sleep through the night[ ]  No [ ]  Yes |  *Other:*  |
|  | I wake during the night and need staff support[ ]  No [ ]  Yes | I need a second living area as I tend to make a lot of sounds[ ]  No [ ]  Yes | I have a hearing impairment[ ]  No [ ]  Yes | I have vision impairment[ ]  No [ ]  Yes |  *Other:*  |
| **Transition Requirements** |  |
| **Any other Information you would like us to know**  |  |

|  |
| --- |
| **Extra Details** |
| **NDIS Plan** | Plan dates: Agency Managed [ ]  Plan Managed [ ] If Plan Managed, please provide Plan Manager details below * Organisation:
* Contact:
* Email:
* Contact number:

High Intensity Funding [ ]  No [ ]  Yes SDA Funding [ ]  No [ ]  Yes - Amount $ . |
| **Supported Independent Living (SIL)** | SIL funding approved:  | SIL balance remaining:  |
| **Social and Community Participation** | Social and Community Participation ratio approved (e.g. 1:1, 1:3) | Social and Community Participation funding approved in plan | Social and Community Participation balance remaining |
|  |  |  |
| **Person responsible for billing/payment and contact details:** | Name: Email: Contact number:  |
| **Centrelink Income Statement attached** | Yes ☐ To be provided ☐ Not applicable ☐ |

|  |
| --- |
| **Next Steps**[ ]  **I would like to be considered for a placement in an Enlarge Home that suits and meets my needs and goals for Supported Independent Living**[ ]  **I currently have SIL funding and want to transfer from my current provider to Brighter Access, or**[ ]  **I have capacity to explore SIL in my current plan** [ ]  **I would like Enlarge / Brighter Access to organise a SIL quote for me to reside and be supported in an Enlarge Home**  |
| **Name of person signing application** | **Date** | **Role** | **Signature** |
|  |  |  |  |
|  |  |  |  |

Please fill out above the details before sending to our email address:

mycare@brighteraccess.com.au

A member of our team will be in touch as soon as possible. Thank you!