**REFERRAL FORM**

**Eligibility Criteria**

(please select all relevant)

**Person with a Disability/Chronic Health Condition**

* Has a moderate, severe or profound disability, chronic illness or health condition  **Yes  No**
* Is under 65 years (under 50 years if identifying as Aboriginal or Torres Strait Islander)  **Yes  No**
* Has difficulty completing Activities of Daily Living independently  **Yes  No**

**Carer of Person with a Disability/Chronic Health Condition**

* Is an unpaid carer experiencing carer stress  **Yes  No**

**Details of Person Completing Form**

|  |  |
| --- | --- |
| Name |  |
| Relationship/Agency/Position |  |
| Contact Details |  |

**What support are you requesting?**

|  |
| --- |
|  |

**Details of Current Supports/Funding (e.g NDIS, TAC, Worksafe, Carers Victoria, Grants etc)**

|  |
| --- |
|  |

**NOTE:** NDIS participants are generally not eligible to access HACC-PYP services as it is the responsibility of the NDIS to fund reasonable and necessary disability related supports.

**Details of Person with a Disability/Chronic Health Condition**

|  |  |
| --- | --- |
| UR Number (if applicable) |  |
| Full Name |  |
| Address |  |
| Date of Birth |  |
| Contact Number |  |
| Email Address |  |
| Country of Birth |  |
| Language Spoken |  |
| Pension Type and Number (if applicable) | Disability  Job Seeker  Aged  Other # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Person Identifies as Aboriginal or Torres Strait Islander | Yes  No  Prefer not to say |
| Refugee/Asylum Seeker status | Yes  No  Year of arrival \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Medicare Number | Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reference # \_\_\_\_\_ |
| Communication Requirements | Interpreter  Via Carer  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Living Arrangements | Lives alone  Lives with family/friends/carer  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Accommodation Type | Owns/purchasing  Private rental  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Health Conditions and/or Disabilities**

|  |
| --- |
|  |

**Carer Details (if applicable)**

|  |  |
| --- | --- |
| Full Name |  |
| Address |  |
| Country of Birth/Date of Birth |  |
| Contact Number |  |
| Email Address |  |
| Language Spoken |  |
| Relationship to person seeking assessment |  |
| Living arrangements |  |
| Cares for more than one person |  |

**Emergency Contact Details (if different from above)**

|  |  |
| --- | --- |
| Full Name |  |
| Address |  |
| Contact Number |  |
| Email Address |  |
| Date of Birth |  |

**GP Details**

|  |  |
| --- | --- |
| Doctors Name |  |
| Medical Centre Name |  |
| Address |  |
| Contact Number |  |
| Email Address |  |

**Referring Agency (if applicable)**

|  |  |
| --- | --- |
| Name of Organisation |  |
| Referrer Name/Position |  |
| Contact Number |  |
| Email |  |
| Has the client provided consent for the referral? | Yes  No |
| Assessment Priority | Urgent  Non-urgent |
| Feedback required | Yes  No |

Please send completed referral forms and supporting documents to the HACC**-**PYP Assessment officer:

Email: [haccpypintake@melton.vic.gov.au](mailto:haccpypintake@melton.vic.gov.au)

Post: Melton City Council, Attention: Community Care, PO Box 21 Melton Vic 3337.

Phone: 9747 7200 if you require assistance.