Home and Community Care Program for Younger People

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.

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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 ________________________________

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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	

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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
Post: Melton City Council, Attention: Community Care, PO Box 21 Melton Vic 3337.
Phone: 9747 7200 if you require assistance.