|  |
| --- |
| □ CHSP □NDIS □CTP-□ N/H □ TEMP DATE Received:  |
| **AC#:** WALLET CHECK: required □completed □ DATE Approved: |

# **OFFICE USE ONLY:**

# **Consumer Registration Form/Service Care Plan**

**Please complete both sides of form giving as much information as possible so that we can assess your application for services. Please contact the office to confirm your application.**

**Details:**

|  |  |
| --- | --- |
| First Name: | Last Name: |
| D.O.B: | Home:Mobile: |
| Other contact names & numbers: |  |
| Country of Birth: | Language Spoken at home: |

**Need help to communicate?** YES□ NO□……………………………………………..

**Home Address:**

|  |
| --- |
|  |
|  **Postcode:** |

**Email:**

|  |  |
| --- | --- |
|  | Would you like to join our email subscription to receive a regular copy of our Newsletter? □ YES □ NO |

**Gender:**

□Male □Female □ Intersex Indeterminate □ Not Stated / Inadequately Described

**What do we need to be aware of in how your supports are provided: e.g.** What assistance is required, cultural & faith considerations, gender of support staff, what good support looks like to you, do’s and don’ts etc. Please provide details/ instructions: …………………………………………………………………………………………………………………………………………….

....................................................................................................................................................................................................................................................................................................................................................................................................

**Emergency & Other Contacts**

Do you have a:

Service Provider for Home Care Package: □ YES □ NO

Emergency contacts □ YES □ NO

Next of Kin, Carer, Advocate □ YES □ NO

If answered YES to any provide details and any other important contacts:

**Emergency and Other Contacts:**

|  |  |  |  |
| --- | --- | --- | --- |
| RELATIONSHIP: | NAME | PHONE | ADDRESS |
| Emergency Contact  |  |  |  |
| Emergency Contact  |  |  |  |
| Local Doctor |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Please circle YES or NO to indicate if you need or receive assistance for the following:**

 **Comments:**

Is this a workers compensation or insurance claim? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you move independently from your home to the vehicle? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you manage 2 to 3 steps independently? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you manoeuvre independently in and out of the vehicle? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you manage alone at your destination? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will a carer/attendant travel with you to provide any necessary help? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If YES** will the attendant be travelling with a mobility aid?

□No mobility aids □Walking stick □Other…………………………

Do you need to use a mobility aid or other equipment when you travel? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If YES** List equipment/ mobility aid used:

□ Walker/ Rollator □ Wheelchair □ Walking stick □ Oxygen □ Guide dog □ Other……………………

Do you require a vehicle with a hoist/ ramp:YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Will you need to access to medical transport? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a disability or any health issues?

that may be relevant to you receiving transport services. YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If YES** disability type:

□ Intellectual Learning □ Not Stated / Inadequately Described

□ Physical / Diverse □ Psychiatric

□ Sensory / Speech Comments:……………………………………

Are there any vehicle access issues to your home? YES or NO

e.g no stopping, no driveway. IF provide details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate if you need or receive assistance for the following:**

Help at Home? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

One on One Social Support? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal Care? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Care? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Travel Training? YES or NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pension:**

□ Aged □ Disability Support Pension □ Other □ Self-Funded □ No pension

**Pension Status:**

□Full □ None □ Part □ Neither

**Department of Veteran Affairs (DVA) Status:**

□Gold □ Orange □ White □ No DVA entitlement

**Indigenous Status**:

□ Aboriginal □ Aboriginal and Torres Strait Islander

□ No □ Not Stated / Inadequately Described □ Torres Strait Islander

**Client Living Arrangements**:

□ Couple □ Couple with Dependant[s]

□ Group [Related Adults] □ Group [Unrelated Adults]

□ Homeless/ No Household □ Not Stated/ Inadequately Described

□ Single [Person Living Alone] □ Sole Parent with Dependant[s]

**Accommodation Setting:**

□ Boarding House □ Crisis Emergency or Transition

□ Independent Living Unit □ Indigenous Community / Settlement

□ Institutional Setting (i.e. Residential Aged Care, Hospital)

□ Not Stated □ Other

□ Private Residence –Client or Family Owned / Purchasing

□ Private Residence - Private Rental □ Private Residence - Public Rental

□ Public Shelter □ Supported Accommodation

**Urgent Transport:**

Do you have any immediate/ urgent, transport requirements YES □ or NO □

If YES provide:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date required:** | **Pick up from:** | **Destination:** | **Appointment time:** | **Return trip** | **Carer going?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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| --- |
| **Consent:**Transport for NSW provides funding to St George Community Transport (STGCT) to provide services under various government programs including Commonwealth Home Support Program. As part of our funding contract we are required to forward quarterly reports to our funding body. This report contains de-identified data for statistical and funding purposes only. Please note that this information does not include your name or any personal details. Please indicate consent for your de-identified details being included in these statistics. **Consent** for STGCT to collect and use personal information: **YES or NO** **Do you consent** for future contact for survey/ research/ evaluation: **YES or NO****Privacy & Confidentiality:** St George Community Transport (STGCT) respects your privacy and information disclosed to us will be private and confidential. We do not give your information to any agency, other people or organisations without your consent. Please note that you will: * receive a form to register your written consent for STGCT to Store and Share your information.
* receive a Media Release form to complete.
* at any time during the registration process with STGCT or while you are receiving services form STGCT, you can change your consent or discontinue using our services.
* You can opt out of or change your consent in relation to your media release or consent to store and share information at any time.
* Please call our office on 02 9585 3000 or email us at reception@stgct.org.au and we will send you a new form/s to complete.
 |

**Referral Comments:**………………………………………………………………………………………………….

………………………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………

**What services would you like to receive?**............................................................................................................

……………………………………………………………………………………………………………………………….

**By using our services what do you hope to achieve?**

i.e. Improved health, reduced social isolation, medical needs;

|  |  |  |
| --- | --- | --- |
| **Goal** | **Outcome** | **Achieved by when** |
|  |  |  |
|  |  |  |
|  |  |  |

**Referral:**

How did you hear about St George Community Transport? ..........................................................................................

Eg: did you attend a presentation? □ Receive a brochure in your mailbox? □ Did a friend tell you about us? □

Did your doctor/ specialist’s reception have a brochure? □ Found our website? □ Internet search? □ Or other ………?

**Referrers Details:**

Contact Name: ................................ Organisation: ................................ Phone: ................................

**Assessor notes: (Please indicate if the client requires a home risk assessment)** ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

|  |  |
| --- | --- |
| **OFFICE USE ONLY** | Date & Signature |
| **Explain:**□ How to make a booking □ 3 days (or more) Notice □ Costs□ What happens on the day of travel□ Social Outing | **Complete**Route Match □MAC accepted □Welcome Letter □ Email Subscription □ | …………………………………………………..……. ………………………………………………………… |

|  |
| --- |
| **OFFICE USE ONLY (***CTP Registrations)* |
| Receiving services under any of these government funded programs?□ CHSP: Commonwealth Home Support Program□ CCSP: Community Care Supports Program□ TTSS:  Taxi Transport Subsidy Scheme□ ASTP: Assisted School Travel Program□ NDIS: National Disability Insurance Scheme□ NEPT: Patient Transport Service PTS (formerly known as NEPT) |