



Referral Form

Assistance with Care and Housing for the Aged (ACHA) Program

1. Surname _____ First Name _____ 2. ACHA ID _____

3. Address on referral _____ P/Code _____

Phone Number _____ 4. Date of Referral ____ / ____ / ____

5. Date of Birth ____ / ____ / ____ 6. ACHA Client Yes / No

7. Gender - Male Female

8. Aboriginal / Torres Strait Islander Yes No

9. Non English Speaking Background Yes No

Country of Origin _____

10. Current Residence:

Private Rental Shared insecure informal
Not for Profit/Public Nil / Homeless

11. Current Type:

House SAAP/Crisis Accommodation Flat/Unit/Villa
Caravan Other _____ Homeless

12. Source of Income

Centrelink Pension Type Centrelink Payment DVA Pension Other

Pension/DVA No _____ Ambulance No _____ Expiry date _____

Medicare No _____ Bank Details _____

13. Source of Referral

- | | | | | | |
|------------------------------|--------------------------|------------|--------------------------|--------------------------|--------------------------|
| Crisis Accommodation Service | <input type="checkbox"/> | Centrelink | <input type="checkbox"/> | HACC Service | <input type="checkbox"/> |
| ACAT / Hospital | <input type="checkbox"/> | GP | <input type="checkbox"/> | Public Housing Authority | <input type="checkbox"/> |
| Housing Advice Service | <input type="checkbox"/> | Day Centre | <input type="checkbox"/> | Other _____ | <input type="checkbox"/> |
| Social Work Department | <input type="checkbox"/> | | | | |

14. Contact Person: _____ **Phone:** _____

15 Reason for Referral

- | | | | | | |
|-------------|--------------------------|-----------------------------|--------------------------|--------------------|--------------------------|
| Rehousing | <input type="checkbox"/> | Information | <input type="checkbox"/> | Housing Assessment | <input type="checkbox"/> |
| Support | <input type="checkbox"/> | Community Aged Care package | <input type="checkbox"/> | | |
| Other _____ | <input type="checkbox"/> | | | | |

16. Need for Assistance

- | | | | | | |
|---------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------------|
| Mobility | <input type="checkbox"/> | Behavior | <input type="checkbox"/> | Compliance with Medical/ | |
| Personal Care | <input type="checkbox"/> | Continence | <input type="checkbox"/> | Health programs | <input type="checkbox"/> |
| Housekeeping | <input type="checkbox"/> | Social Supports | <input type="checkbox"/> | Support with Finances | <input type="checkbox"/> |
| Advocacy | <input type="checkbox"/> | Monitoring Nutrition | <input type="checkbox"/> | Safety and Security | <input type="checkbox"/> |
| Other | <input type="checkbox"/> | Communication | <input type="checkbox"/> | | |

17. Address of relocation _____ P/Code _____

Phone Number _____ Type / Tenure _____

18. Other Services / Useful phone numbers

(Homeswest / Landlord, Chemist, Day Centre, Meals on Wheels, HACC or Silver Chain, Neighbour or other informal support)

- _____ Phone _____
- _____ Phone _____
- _____ Phone _____
- _____ Phone _____
- _____ Phone _____
- _____ Phone _____

