putting you first.

QLSS

Quality Living and Support Services

Supported Independent Living - Referral Form

SIL REFERRAL FORM

SUPPORTED ACCOMMODATION SERVICES

What is SIL:

Supported Independent Living (SIL) is a model of Supported Accommodation funded by the National Disability Insurance Scheme (NDIS).

SIL is generally for people living in shared supported arrangements. Participants living on their own, requiring 24/7 care, may also be eligible for SIL when it is required as a result of high support needs.

Residents will receive support with everyday tasks like cleaning, cooking and personal care. Other areas of supports may be with:

- maintaining a household.
- building skills for shopping and cooking for healthy eating.
- accessing local community groups & activities.
- developing and maintaining connections with family and friends.
- specialised behaviour support.

Quality Living and Support Services uses a mix of highly trained and experienced staff who can provide a safe and supportive environment in our group homes.

Who is SIL for:

Our SIL services are suitable for people between the ages of 18 and 65 who live with a psychosocial-disability. Our residents are encouraged and supported to live as independently as possible. Each client will have an individually tailored program of supports, depending on their needs and how they want to live their life. There are three levels of support provided under SIL:

- Lower needs - This support provides supervision of living arrangements as a whole including occasional to intermittent prompting to undertake household tasks and/or self- care activities. This supervision is not usually provided 24/7.
- Standard needs – This support provides 24/7 support including active assistance or supervision of most daily tasks and regular inactive overnight supports (sleepover shift)
- Higher needs – This support provides intensive 24/7 support including continual, active assistance with all daily tasks, specialised behaviours support and active overnight support.

How do you access the service:

Supported Independent Living (SIL) is available for people who require access to 24/7 support and is funded through NDIS Core supports.

To be eligible, you need to fit the following criteria:

- You have an NDIS Plan with approval for Supported Independent Living OR you have funding for Investigating Housing Solutions and expect that your Plan will include Supported Independent Living funding
- You require access to 24/7 support
- You are over the age of 18

Supporting documents checklist:

- ☐ Primary Diagnosis of Mental Health disorder
- Current Client Management Plan
- Brief Risk Assessment completed by a clinician
- Current Mental Health Treatment/Care Plan
- Recent Discharge Summaries
- ☐ Occupational Therapy (OT) Assessment (if applicable)
- Details of Forensic History (if relevant)
- Any current Treatment Authority
- ☐ Medication regime
- ☐ NDIS plan (if applicable)
- ☐ Physical Health Assessment completed by a GP or attending Doctor

A referral will be deemed incomplete until we have received all of this information.

SIL REFERRAL FORM

REFERRER DETAILS

Name | Agency/Position

Postal Address | Postcode

Phone | Email

How did you hear about us?

- ◯ Website
- ◯ Friend/Family/Another Client
- ◯ Flyer
- ◯ Social Media
- ◯ Radio
- ◯ Advertising
- ◯ Event
- ◯ Google
- ◯ Other

Applicant to Complete

First Name | Family Name

Preferred Name | Date of Birth

Address | Postcode

Phone | Mobile | Email

Gender:

- ◯ Female
- ◯ Transgender Female (MTF)
- ◯ Male
- ◯ Prefer not to disclose
- ◯ Different Identity (please describe)
- ◯ Transgender Male (FTM)
- ◯ Non Binary
- ◯ Self describe

Sexuality:

- ◯ Straight/Heterosexual
- ◯ Lesbian/Gay/Homosexual
- ◯ Bisexual
- ◯ Unsure
- ◯ Self describe
- ◯ Prefer not to disclose

Intersex Status:

- ◯ Yes
- ◯ No
- ◯ Unsure
- ◯ Prefer not to disclose

SIL REFERRAL FORM

APPLICANT TO COMPLETE

Pronouns:
- ◯ They/Them/Theirs
- ◯ She/Her/Hers
- ◯ He/ Him/His
- ◯ My Name/None
- ◯ Other _____

Relationship Status:
- ◯ Single
- ◯ Married
- ◯ Separated
- ◯ Self describe _____
- ◯ Divorced
- ◯ Widowed
- ◯ Defacto

Aboriginal ◯ Yes ◯ No Torres Straight origin ◯ Yes ◯ No Ethnicity _____

Country of Birth _____ Culturally & Linguistically Diverse ◯ Yes ◯ No

Main Language spoken ◯ English ◯ Other Other _____

Interpreter required ◯ Yes ◯ No Children ◯ Yes ◯ No Visa Status _____

Occupation _____

Source of income:
- ☐ Age Pension
- ☐ Carer Allowance
- ☐ Disability Pension
- ☐ Department of Veteran's Affairs
- ☐ Unemployment (Newstart)
- ☐ Youth Allowance
- ☐ Paid Work
- ☐ Other _____

Living:
- ◯ Living Independently
- ◯ Living with family member/carer
- ◯ Other _____

Hold a DVA Card? ◯ Yes ◯ No If yes, what type? ◯ Gold ◯ White ◯ Other

Centrelink number _____ Expiry _____

Medicare number _____ Expiry _____

Private health cover: ◯ Yes ◯ No Provider _____ Member ID _____

Ambulance Cover: ◯ Yes ◯ No

Are you currently receiving services from another Service Provider? ◯ Yes ◯ No

SIL REFERRAL FORM

CONTACTS

Nominated support person (Next of kin / Alternative contact)

Name | Phone | Mobile

Email | Relationship

Do you have a Mental Health Case Manager?

◯ Yes ◯ No

Name | Organisation

Phone | Mobile | Email

Do you have a guardian appointed (formal or informal)?

◯ Yes ◯ No

Name | Phone | Mobile

Email

Do you have a public trustee or a financial guardian?

◯ Yes ◯ No

Name | Phone | Mobile

Email

Do you have a GP?

◯ Yes ◯ No

Name | Phone | Mobile

Email

Which of the above is your preferred contact?

◯ Support Person ◯ Case Manager ◯ Guardian Appointed ◯ Public trustee ◯ GP

Preferred method of contact

◯ Text ◯ Phone call ◯ Email ◯ Mail

SIL REFERRAL FORM

HEALTH AND WELLBEING

Please attach a Physical Health Assessment form

Existing NDIS Plan? ◯ Yes ◯ No NDIS Plan Number (Please attach)

Formal mental health diagnosis? ◯ Yes ◯ No
If yes, please provide details

Drug and Alcohol Use

Provide details where appropriate.

Drug type	History of use	Current use
Alcohol		
T.H.C. (Cannabis)		
Benzodiazapines		
Opioids		
Stimulants ☐ Amphetamines ☐ Dexamphetamines A		
Other ☐ Hallucinogens ☐ MDMA - Ecstasy ☐ Prescription Drugs ☐ Solvents		
Cigarettes		

Any associated risk behaviours or problems:

(Injecting, overdoses, Hepatitis status)

While I am a resident, if I am considered to be using drugs and alcohol which is impacting on my recovery, I agree to work with an appropriate Drug and Alcohol Service.*

☐ Agree

SIL REFERRAL FORM

MENTAL AND PHYSICAL HEALTH

Medical Conditions

Do you have any physical/health issues or disabilities (tick all that apply and provide details below):

Diabetes	☐ Yes	☐ No		Podiatry	☐ Yes	☐ No	
Bruise or bleed easily	☐ Yes	☐ No		Dental	☐ Yes	☐ No	
Heart complaints	☐ Yes	☐ No		Ulcerations	☐ Yes	☐ No	
Liver disease	☐ Yes	☐ No		Asthma	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No		Allergies	☐ Yes	☐ No	
HIV/AIDS	☐ Yes	☐ No		Allergic to medication	☐ Yes	☐ No	
Blood pressure	☐ Yes	☐ No		Acquired head injury	☐ Yes	☐ No	
Speech	☐ Yes	☐ No		Thyroid problems	☐ Yes	☐ No	
Visual	☐ Yes	☐ No		Eating disorders	☐ Yes	☐ No	
Hearing	☐ Yes	☐ No		Substance abuse	☐ Yes	☐ No	
Mobility impairments	☐ Yes	☐ No		Women's health screens	☐ Yes	☐ No	
Respiratory disease	☐ Yes	☐ No		Men's health screens	☐ Yes	☐ No	
Intersex variation	☐ Yes	☐ No		Transgender health screens	☐ Yes	☐ No	
Other *(please state)*	☐ Yes	☐ No					

If yes, please provide details. Include the impact on your life and relating support needs.

Do you have any mobility aids? ☐ Yes ☐ No

If yes, please provide details.

SIL REFERRAL FORM

MENTAL AND PHYSICAL HEALTH

Medication

How do you feel about taking medication?

Do you take regular medication? *(Please attach your medication regime)*

Yes No

Do you require support taking your medication?

Yes No

Do you use a Webster Pack?

Yes No

Any hospital admissions in the last 12 months?

Provide full details of any admissions (including date and reason):

SIL REFERRAL FORM

HISTORY AND SUPPORT

Forensic History

Do you have any past or current legal issues?*

◯ Yes ◯ No

If yes, please provide details:

Support Needs

Are there any particular tasks you find challenging?

What support do you need? *(Tick all that apply)*

- ☐ Getting in/out of bed
- ☐ Bathing
- ☐ Dressing/undressing
- ☐ With continence
- ☐ Toileting
- ☐ Washing
- ☐ Cooking
- ☐ Medication
- ☐ Eating
- ☐ Accessing counselling/talking to someone
- ☐ Laundry
- ☐ Shopping
- ☐ Gardening
- ☐ Cleaning
- ☐ Keeping safe
- ☐ Communicating
- ☐ With documentation
- ☐ Transport
- ☐ Budgeting
- ☐ Accessing medical/health appointments
- ☐ Emotional support
- ☐ Engaging with social groups
- ☐ Advocacy *(someone to talk on your behalf)*
- ☐ Information of services/support
- ☐ Social/family contact
- ☐ Psycho-education *(e.g. stress management)*
- ☐ Computer/IT skills
- ☐ Family relationships
- ☐ Others *(please specify)*

Please specify:

Additional comments:

SIL REFERRAL FORM

CONSENT

Terms and Conditions

I acknowledge the information provided is true and correct. I agree that Quality Living and Support Services may contact my health service providers to gather additional information to assist with my referral if needed. I consent to this referral being submitted for consideration of Quality Living and Support Services - Supported Independent Living services.*

*Signature** *Date**

If Guardian, provide a copy of your Guardian Order issued by the State Administrative Tribunal.

Guardian signature *Date*

putting you first.

QLSS

Quality Living and Support Services

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