REFERRAL FORM

Home & Community Care Program for Younger People (HACC PYP)

Please send completed referral forms and supporting documents to the HACC-PYP Assessment team via:

Email: intake@mhacare.org.au Post: Intake PO Box 376 Yarrawonga VIC 3730

In person: Head Office 22 Orr Street Yarrawonga VIC 3730

SECTION 1 – Details of person requesting HACC PYP Assessment To be completed by person requiring assessment, carer or health professional/organisation.	
Date of referral	
Full Name	
Date of Birth	
Address	
Contact number	
Email	
Sex:	☐ Male ☐ Female ☐ non-binary ☐ Prefer not to say
Ethnic Origin:	☐ Aboriginal ☐ Torres Strait Islander ☐ Neither Aboriginal or Torres Strait Islander
Country of Birth	
Preferred Language	
Interpreter Required?	☐ No ☐ Yes
Marital Status	☐ Defacto ☐ Divorced ☐ Married ☐ Separated ☐ Widowed ☐ Single
Medicare Number:	Medicare Individual Ref No
Pension Type	☐ None ☐ Disability ☐ Carer Payment ☐ Carer Allowance ☐ Unemployment/ Newstart Pension No: _ _ _-_ _ _-_ _ _ _

Emergency Contact	Name: Phone: Relationship to Care Recipient:
Employment Status	☐ Full Time Employment ☐ Part Time Employment ☐ Casual Employment ☐ Volunteer ☐ Not Employed
NDIS Status	☐ Never applied ☐ Applied, not eligible ☐ Applied, waiting on NDIS Approval
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.	
Are you receiving support with any other formal services eg. Beyond housing, Wellways, Post acute care, Psychology.	☐ None ☐ Yes – (please specify below):

Section 2- Eligibility Criteria of person requesting HACC PYP Assessment (Please select all relevant) To be completed by person requiring assessment, carer or health professional/organisation	
Has a chronic illness, mental health, disability or other condition that has an impact on their day-to-day living and ability to participate in the community?	☐ Yes ☐ No
Has difficulty completing Activities of Daily Living independently?	☐ Yes ☐ No
Are at risk of losing their independence without support?	☐ Yes ☐ No
Are you a Carer of Person with a Disability / Chronic Health Condition needing support in your caring role?	☐ Yes ☐ No

MHA CARE
Your home + personal care made easy

Is under 65 years (under 50 years if identifying as Aboriginal or Torres Strait Islander)?	☐ Yes ☐ No

*If care recipient does not identify as Aboriginal or Torres Strait Islander and is over the age of 65 years or if care recipient identifies as Aboriginal or Torres Strait Islander and is over the age of 50 years, please refer to My Aged Care 1800 200 422

Reason for Referral / Support Needs

(Please provide details of the support required, e.g., meals, social activities, community access, health support.)

Reason for Referral:

- ☐ Chronic illness
- ☐ Mental health
- ☐ Disability
- ☐ Other condition/issue that has an impact on their day-to-day living and ability to participate in the community

Support Needs:

- ☐ In home Respite
- ☐ Domestic Assistance
- ☐ Meal Assistance
- ☐ Cooked meals assistance
- ☐ Personal Care (showering, shopping)
- ☐ Property Maintenance (eg.Gutter clean, Smoke detectors)
- ☐ Social Support
- ☐ Planned activity group
- ☐ Capacity building activity (one off/short term service support to help build skills to remain living independently
- ☐ Service linkages

Comments:

SECTION 3 – Health and safety. **Please list below any health or safety concerns that we should be aware of?** (eg. weapons stored on property, behaviours, smoker, animals) To be completed by person requiring assessment, carer or health professional/organisation

Section 4 – To be complete by Health professional or referring organisation	
Organisation	
Referred By	
Contact Phone No	
Email address	
Has the Client consented to this referral and the sharing of their information with MHA Care?	☐ Yes ☐ No
Diagnosis/Condition:	
Reason for Referral:	

Consent

I consent to MHA Care collecting and using my personal information to assess eligibility for HACC PYP services and to communicate with relevant health professionals or service providers as needed.

Client Signature: _____ Date: ____/____/_____

Referrer Signature (if applicable): _____Date:____/____/___