



**MHA CARE**

*Your home + personal care made easy*

# 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 Yarrowonga VIC 3730

In person: Head Office 22 Orr Street Yarrowonga 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> non-binary <input type="checkbox"/> Prefer not to say
Ethnic Origin:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Neither Aboriginal or Torres Strait Islander
Country of Birth	
Preferred Language	
Interpreter Required?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Marital Status	<input type="checkbox"/> De facto <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Single
Medicare Number:	Medicare Individual Ref No
Pension Type	<input type="checkbox"/> None <input type="checkbox"/> Disability <input type="checkbox"/> Carer Payment <input type="checkbox"/> Carer Allowance <input type="checkbox"/> Unemployment/ Newstart  Pension No: _ _ _ - _ _ _ - _ _ _ _



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Emergency Contact	Name: Phone: Relationship to Care Recipient:
Employment Status	<input type="checkbox"/> Full Time Employment <input type="checkbox"/> Part Time Employment <input type="checkbox"/> Casual Employment <input type="checkbox"/> Volunteer <input type="checkbox"/> Not Employed
NDIS Status	<input type="checkbox"/> Never applied <input type="checkbox"/> Applied, not eligible <input type="checkbox"/> 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.	<input type="checkbox"/> None <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has difficulty completing Activities of Daily Living independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are at risk of losing their independence without support?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you a Carer of Person with a Disability / Chronic Health Condition needing support in your caring role?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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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:


*Please tab down in comment box to go to next line*



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**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


*Please tab down in comment box to go to next line*

**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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis/Condition:	
Reason for Referral:	

*Please tab down in comment box to go to next line*

**Consent**

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

Client Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referrer Signature (if applicable): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_