Housing and Accommodation Support Initiative (HASI) –

Referral Form Shoalhaven

1. AGREEMENT TO APPLY FOR SERVICE & RELEASE INFORMATION

I _____ give my consent to Grand Pacific Health to seek information from the following people to help them make a decision about my application for HASI services.

ORGANISATION	CONTACT PERSON	PHONE
• Community Mental Health Team		
• Housing Provider		
• Doctor		
• Family or Carer		
• Counsellor		
•		
•		

I understand that information about my application may be shared in confidential meetings with HASI partners where decisions about eligibility are made. This information may also be shared between HASI and Enhanced Adult Community Living Support (CLS) providers for allocation.

Applicant's Signature:		Date:	/ /
Referrer's Name Organisation and Signature:		Date:	/ /

2. PERSONAL INFORMATION

Full Name:						
Street Address:			Suburb:			
			Postcode:			
Phone:		Mobile:				
Email:						
Date of birth:	/ /	Gender:	□ Male	□ Female	□ Other	
Cultural Background:	□ Aboriginal	□ Torres Strait Islander	□ Both Aboriginal and Torres Strait Islander	□ Neither	□ Decline to answer	□ Culturally & Linguistically Diverse
Preferred Language:		Interpreter Required:		□ Yes	□ No	
Preferred Method of Contact:	□ Mobile	□ SMS	□ Home Phone		□ Face to Face	□ Email

3. EMERGENCY CONTACT DETAILS AND/OR NEXT OF KIN			
Full Name:			
Street Address:		Suburb:	
		Post Code:	
Phone:		Mobile:	
Email:			
Relationship:			

4. HEALTH INFORMATION			
What are your diagnosed mental illnesses?			
What other health concerns or illnesses do you have?			
Treatment under a Community Treatment Order	□ Yes Attached	□ Not Attached but available from Name: Organisation: Contact details:	□ No
Do you have a recent clinical assessment available? If yes, please attach a copy.	□ Yes Attached	□ Not Attached but available from Name: Organisation: Contact details:	□ No
Do you have a care plan? If yes, please attach a copy.	□ Yes Attached	□ Not Attached but available from Name: Organisation: Contact details:	□ No
Do you have a recent risk assessment? If yes please attach a copy	□ Yes Attached	□ Not Attached but available from Name: Organisation: Contact details:	□ No

5. HOUSING INFORMATION

Who is your housing with? E.g. NSW Housing, private rental, community housing, boarding house, private rental, homeless			
Who do you live with at the moment? E.g. alone, with family, friends, pets			
Has an Application for Housing Assistance been submitted for you:	□ Yes	□ No	□ Not Applicable
If Yes, Application Reference Number:			
In the past have you had any difficulties in getting or keeping housing?			

6. CURRENT THERAPIES, SUPPORTS AND SERVICES

List any supports and/or services that you currently receive assistance from: Are there any you other services you would like to be engaged with?

7. MORE ABOUT YOU

What would you like help with? How would you like us to support you?

8. OTHER RELEVANT INFORMATION

Is there any information that would help to support you with your health and/or safety e.g. have you had difficulty engaging services, social history, family concerns, drug and alcohol issues, specific worker requirements (i.e. do you have a preference with working with either male or female workers?):

9. REFERRING PERSONS DETAILS

Full Name:			
Street Address:		Suburb:	
		Post Code:	
Phone:		Mobile:	
Email:			

Please outline the reason for referral including any issues that may be placing their tenancy at risk, antisocial behaviour action, NCAT involvement.

10. NSW GOVERNMENT HEALTH – RELEASE OF INFORMATION

It is a requirement of this program that the Illawarra Shoalhaven Local Health District (ISLHD) provide relevant information to inform decisions regarding eligibility and recovery planning. If you not currently engaged with the ISLHD Mental Health Service, we can support you to meet with one of their staff to discuss your eligibility.

If you are currently receiving support from the ISLHD Mental Health Service we will confirm your consent for Grand Pacific Health to contact them and ask for some additional information relating your mental health, current circumstances as well information relating to safety.
We may ask for copies of the following documents:

- Mental Health Care Plan
- Mental Health Review/Mental Health Assessment form
- Discharge Summary (where relevant)
- Mental Health Risk Assessment

Thank you for referring to the Grand Pacific Health HASI Team

A Grand Pacific Health HASI Worker will be in contact to discuss this referral

Ph: 1800 228 987 **Secure Fax: 02 4226 6489**