RESPITE APPLICATION

CODA

Section 1: Person requiring access to respite	
First Name	Surname
Primary disability	Other disability
Date of birth	
Is the applicant of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No ☐ Both	
Address	
Suburb	Postcode
Phone number	Email
Medicare No:	Pension No:
Private Health Care? Yes ☐ No ☐	Fund Name: Member No:
Does the Applicant have a Multi-Purpose Taxi Card? Yes ☐ No ☐	Card No:
Does the Applicant have a Companion Card? Yes ☐ No ☐ *If yes, please ensure these cards are available during respite stay*	Card No:
Who does the Applicant live with: ☐ The carer stated below, OR ☐ Independently	

Section 2: Carer details	
First Name/s	Surname
Address	
Suburb	Postcode
Phone	Mobile
Email	
Relationship to person requiring respite	
Carer/s Age *(optional)*	

Section 3: Person completing this form *(if other than the applicant or primary contact person)*	
First Name	Surname
Organisation (if applicable)	
Address	
Suburb	Postcode
Phone	Mobile
Email	
Relationship to person requiring respite	

3.1 Emergency Contacts			
If primary carer/s are unavailable, please contact:			
Name	Relationship to Applicant	Address	Contact No

3.2 Does the applicant have a legal guardian?
Yes ☐ No ☐ If yes, please provide the legal guardians' name and phone number.

3.3 Does the applicant have a financial administrator?
Yes ☐ No ☐ If yes, please provide financial administrators name and phone number.

Current Health Practitioner			
Specialty	**Name**	**Address**	**Phone**
GP			
Psychologist			
Dentist			
Audiologist			
Optometrist			
Paediatrician			
Chemist			
Other			

Current Medication Information

Does the applicant take any regular medication? Yes ☐ No ☐
If yes, please provide the following details for each medication:
**Please attach a copy of a current Treatment Sheet*

Name of Medication	Dose	Time(s) taken	Prescribed by	Treatment for

Current Medical Information	Yes	No
Does the applicant have asthma? If yes, please attach a current asthma plan.		
Does the applicant have epilepsy? If yes, please attach a current epilepsy management plan.		
Are there any current health issues? Please describe		

Current Medical Information, cont.	Yes	No
Has the applicant suffered from measles?		
Has the applicant suffered from rubella?		
Has the applicant suffered from chicken pox?		
Has the applicant suffered from pertussis (whooping cough)?		
Does the applicant have any vision problems?		
Does the applicant wear glasses?		
Does the applicant have any hearing problems?		
Does the applicant wear hearing aids?		
Does the applicant have dentures?		
Does the applicant wear/use any other aids or supports? If yes, please specify:		
Has the applicant had the following immunizations: • Triple Antigen • Diphtheria/Tetanus • Measles/Mumps/Rubella • Hib TTITER (Influenza B) • Pneumovax		
Does the applicant have any allergies? If yes, please describe:		
Does the applicant have any medical requirements that would require specific training, such as a peg feed? If yes, please specify		

Behavioural Issues	Yes	No
Does the applicant have a current Behaviour Support Plan (BSP)? If yes, please attach.		
Does the applicant have any behaviour support needs? If yes, please describe the behaviour and positive behaviour supports used (unless included above)		
Are any of the medications previously listed prescribed to treat conditions related to the described behaviours? If yes, please specify.		
Does the applicant been diagnosed with any mental health issues? If yes, please attach a current Mental Health Plan, which includes the diagnosis and its daily impact, treatment and other services involved.		

Please indicate the support required by the applicant in the following areas:

	Dependent	Needs some assistance	Independent with use of equipment	Independent	Not applicable
Mobility					
Self Care					
Meal Time assistance					
Communication					
Interpersonal Relationships					
Learning/Applying Knowledge/ General Tasks & demands					
Education					
Community Access/Economic Life					
Domestic tasks					
Employment/Working					

Support currently received: What support is the family currently receiving? Please circle one option for each line.			
Facility based respite	REGULAR One weekend per month/ one night per week or more	IRREGULAR Once or twice a year	Not at all
Recreation, youth groups or other social groups	REGULAR One weekend per month/ one night per week or more	IRREGULAR Once or twice a year	Not at all
School holiday programs/camps	REGULAR Every holiday period	IRREGULAR Once or twice a year	Not at all
In home support, specific home help (per week)	9 hours +	5-8 hours	4 or less hours Nil
Family based respite/host program	Regular	Not at all	
Case Management	Regular	None	

Day Programs attended Please provide details of the applicants current day program providers				
Agency	**Days/times**	**Site address**	**Transported by**	**Key Contact**

Respite requested	
Service	Please describe current need/request
Langdon House (Facility based)	
Respite for Older Carers (ROC)	
1:1 Fee for service	

Consent is provided for:	Yes	No
The applicant to be transported in a CODA Inc. vehicle, a staff vehicle or by public transport, where transportation is deemed part of an activity the client is participation in whilst in care		
The person in charge to seek medical treatment or call an ambulance, if deemed necessary, in the event of illness or injury, where it is impracticable to communicate with me. I agree to be responsible for any expenses thereby incurred.		
Photographs and/or video the applicant as part of the services activities		
The use of photographs/video of the individual for the purpose of promoting CODA Inc.		
I,________________________________provide the above consents. ☐ Applicant ☐ Parent ☐ Guardian Signed: ________________________________ Date:		

Declaration
CODA Inc. is required to release statistical information to the Department of Human Services (DHS) and Australian Institute of Health and Welfare (AIHW) about service users, to monitor existing services, plan for future services and for statistical purposes. Your information will be very useful in assisting to plan better services. If you choose not to consent to your information being released, there will be no direct consequences for you. Do you consent to non-identifying information being provided to the Department of Human Services (DHS) and Australian Institute of Health and Welfare (AIHW) for the purposes detailed above? Please tick one ☐ **YES** ☐ **NO Signed:** ____________________________ **Please ensure you sign this section or application will be returned**
All CODA Inc. files are internally and externally audited regularly to ensure quality services are being. Auditors are bound by a confidentiality agreement. Do you consent to your file being viewed for quality review audit purposes? Please tick one ☐ **YES** ☐ **NO Signed:** ____________________________ **Please ensure you sign this section or application will be returned**