



*Referral does not guarantee you will get the support you are seeking, but it does mean the ACT Government is aware of your general needs and circumstances.*

*Disability ACT will use this information to determine your eligibility for support through the School Leaver process. Additionally the information you provide will form part of data collected by the Federal Government through the National Minimum Data Set (NMDS).*

*For information about how Disability ACT will use the information or further information about the School Leavers Process please contact the Disability ACT Information Service 6207 1086.*

*The completed and signed form can be mailed to:*

*Disability ACT Information Service  
Registration of Interest  
GPO Box 158 Canberra City 2601*

*Or contact:  
Disability ACT Information Officer at  
[DisabilityACT@act.gov.au](mailto:DisabilityACT@act.gov.au)*

## 1: Your Details (The details of the person leaving school)

<b>Title (Mr, Mrs, Ms,)</b>	
<b>First Name</b>	
<b>Middle (and other) names</b>	
<b>Surname</b>	

## 2: Personal information

<b>Date Of birth</b>		<b>Age:</b>	
<b>Gender</b>	Male / Female		
<b>Primary language/s spoken at home</b>			
<b>Do you require an interpreter?</b>	Yes/no		
<b>Do you identify as a Aboriginal or Torres Strait Islander?</b>	Yes/no	If yes	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both
<b>Do you use technology to assist in your communication</b>	Yes/no		

## 3: Your School or College

<b>School / College</b>		<b>Year Finishing School</b>	
<b>Teachers Name</b>			

## 4: Your Contact details





<b>Residential Address</b>			
<b>Postal address</b>			
<b>Email address</b>			
<b>Phone Numbers</b>	Home:	Work:	Mobile:
<b>Preferred method of contact (please specify)</b>			

**5: Guardianship details** (if relevant, otherwise leave blank)

*(For more information regarding guardianship please contact the Office of the Public Advocate 6207 0707 or [www.publicadvocate.act.gov.au/](http://www.publicadvocate.act.gov.au/))*

<b>Name &amp; title of legal guardian</b>			
<b>Review date of Guardianship order</b>			
<b>Postal address</b>			
<b>Email address</b>			
<b>Phone Numbers</b>	Home:	Work:	Mobile:





**6: Preferred contact person**

*(The person you would like Disability ACT to contact in relation to your support needs or referral. If not relevant leave blank)*

<b>Name</b>			
<b>Relationship to applicant</b>			
<b>Residential Address</b>			
<b>Postal address</b>			
<b>Email address</b>			
<b>Phone Numbers</b>	Home:	Work:	Mobile:

**7: Eligibility information**

<b>I am an Australian citizen Permanent Resident</b>	Yes/no
<b>I permanently reside within the Australian Capital Territory.</b>	Yes/no





**8: Information about your disability**

*(Please identify your primary disability and, if relevant other disabilities that affect you)*

Disability	Primary (tick one only)	Secondary
<b>Intellectual</b>		
<b>Specific learning/ADD – other than an intellectual disability</b>		
<b>Autism</b>		
<b>Asperger’s Syndrome</b>		
<b>Physical</b>		
<b>Acquired Brain Injury</b>		
<b>Neurological – including Epilepsy and Alzheimer's Disease</b>		
<b>Deaf/blind-dual sensory</b>		
<b>Vision</b>		
<b>Hearing</b>		
<b>Speech</b>		
<b>Psychiatric</b>		

<b>Please provide the name/ type/ diagnosis of your primary disability</b>	
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<b>How does this affect you?/ What support do you need because of your disability</b>





## 9: Information about current services

(have you used any of the following services in the last 12 months)

Service	Yes/ No	Agency/Contact Person
<b>Advocacy/information referral</b>	Yes/ No	
<b>Domestic Support</b>	Yes/ No	
<b>Community Access services</b>	Yes/ No	
<b>Community Transport</b>	Yes/ No	
<b>Gardening</b>	Yes/ No	
<b>Community Nursing</b>	Yes/ No	
<b>In home personal care</b>	Yes/ No	
<b>Recreation services</b>	Yes/ No	
<b>Respite</b>	Yes/ No	
<b>Therapy</b>	Yes/ No	
<b>Disability ACT</b>	Yes/ No	
<b>Employment</b>	Yes/ No	
<b>Mental Health</b>	Yes/ No	

## 10: Compensation

Have you received compensation as a result of acquiring a disability?	Yes	No
Do you intend to claim or do you have a current claim for compensation as a result of acquiring a disability?	Yes	No



## Agreement and Consent

Please read, sign and date the agreement and consent below.

I/We agree that the information supplied in this application is true and correct.

I/We give consent for Disability ACT to retain this information on paper and electronic files for a period of 12 months from the date of my signature on this form.

I/We give consent for Disability ACT to use the information in this referral to:

- Plan for future disability services in the ACT
- Provide general advice to the ACT and Federal Government about people seeking disability services in the ACT.
- Provide advice to other agencies, departments or service providers, including in relation to any future negotiation of supports for me.

Your signature

Guardian signature (if applicable)

Name	
Signature	
Date	

Name	
Signature	
Date	

Thank you for taking the time to fill in this form.

The Department of Disability, Housing and Community Services aims to ensure that the personal privacy of individuals is protected, and that access to records is provided in compliance with relevant legislation. For further information, please refer the *Privacy Act 1988*, *Health Records (Privacy and Access) Act 1997*.

### For Office use Only

Date Receive \_\_\_\_\_ Date Entered on Data Base \_\_\_\_\_ Review Date \_\_\_\_\_

