



2009 School Leavers Referral for Services

Disability ACT will use this information to determine eligibility for support through the 2009 School Leaver process. Additionally the information you provide will form part of a data collected by the Federal Government through their National Minimum Data Set (NMDS) For more information about this referral form and how Disability ACT will use the information or further information on the 2009 School Leavers Process in addition to support to fill in this form please contact Disability ACT Information service 6207 1086 and they can provide you with

Once completed a copy of the signed form can be mailed to:

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

Or contact our
 Disability ACT Information Officer at
DisabilityACT@act.gov.au

1: Your Details

(The details of the person who has a disability)

Title (Mr, Mrs, Ms,)	
First Name	
Middle (and other) names	
Surname	

2: Personal information

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





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Do you use technology to assist in your communication	Yes/no
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3: Your Contact details

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

4: 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/)

Name & title of legal guardian			
Review date of Guardianship order			
Postal address			
Email address			
Phone Numbers	Home:	Work:	Mobile:





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5: 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)

Name			
Relationship to applicant			
Residential Address			
Postal address			
Email address			
Phone Numbers	Home:	Work:	Mobile:

6: What support services are you seeking?

(refer to page 2 of the Information sheet for details)

- Transitional Support
- Community Access supports
- Assistance to find and participate in meaningful employment, recreation, or social activities

Comments





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7: Eligibility information

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

8: Information about your disability

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

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





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9: Information about current services

(Detail services that you have used in the last 12 months)

Service	Agency/ies
Advocacy/information referral	Yes/ no
Domestic Support	Yes/ no
Community Access services	Yes/ no
Community Transport	Yes/ no
Gardening	Yes/ no
Community Nursing	Yes/ no
In home personal care	Yes/ no
Recreation services	Yes/ no
Respite	Yes/ no
Therapy	Yes/ no
Disability ACT	Yes/ no
Employment (open, targeted or Supported)	Yes/ no

10: Funding

Are you currently in receipt of an Individual Support Package from Disability ACT?	Yes	No
Agency holding funds		
Do you receive a disability support package funding from another state or Territory Government	Yes	No
State/ Territory holding funds		

11: 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





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Agreement and Consent

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

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

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 _____

