

# 2009 Post School Options Application Form



This is an application form for Post School Options for people who have a disability residing in the ACT.

An Information Package about this funding process is available for download from [www.dhcs.act.gov.au/DisabilityACT](http://www.dhcs.act.gov.au/DisabilityACT) or by contacting Disability ACT's Information Service on 6207-1086

The information package will provide information about how Disability ACT will assess applications, what the eligibility and priority criteria are, and the timeframes for the application process.

The application form consists of the following sections:

Section 1: About The Applicant	Must be completed by <b>all applicants</b>
Section 2: Current Circumstances	Must be completed by <b>all applicants</b>
Section 3 Your Goals	Must be completed by <b>all applicants</b>
Section 4: School Leavers	<b>Only to be completed</b> by people leaving school in December 2008
Section 5: Support Requested	Must be completed by <b>all applicants</b>
Agreement and consent	Must be completed by <b>all applicants</b>

The closing date for applications is **21 August 2008**

Applications should be sent to:

**The Manager  
Individual Response Team  
Disability ACT  
GPO Box 158  
CANBERRA CITY ACT 2601**

## Section 1: About the applicant

### 1: Personal details:

Title (Mr, Mrs, Ms,)			
First Name			
Middle (and other) names			
Surname			
Gender (please circle)	Male	Female	
Residential Address			
Postal Address			
Telephone Number(s)	Home	Work	Mob
Email Address (if applicable)			
Date of birth:		Age:	

## 2: Guardianship:

If you do not have a legal guardian please leave blank and move on to the next question.

Name and title of legal guardian?	
Address of Guardian	
Contact number for Guardian	
What is the review date of the guardianship order	
What is your relationship to the applicant (other than as guardian)?	

## 3: Contact person (if relevant):

Complete these details if you wish someone other than the applicant to be the contact person for this application. If you don't want to nominate a contact person, leave this blank and move on to the next question.

Name of preferred contact	
Relationship to applicant	
Residential Address	
Postal Address	
Telephone Number	
Email Address (if applicable)	

## 4: Cultural heritage:

Primary language(s) spoken at home	
Do you require an interpreter?	
Do you identify as an Aboriginal or Torres Strait Islander?	

## 5: Citizenship:

If you are not an Australian citizen or permanent resident, you are not eligible for Disability support

I am an Australian citizen, or permanent resident and can verify this (upon request only) by producing supporting documentation.	Yes	No
--	-----	----

## 6: ACT Residency Status:

If you are not an ACT Resident you are not eligible for Disability support.

From 5 July 2008, I will have been living continuously in the ACT for a period of 6 months, and can verify this (upon request only) by producing supporting documentation. OR	Yes	No
I am a permanent resident of the ACT, but due to the need to access supports currently not available in the ACT / rehabilitation, I have been absent from the ACT for less than to 2 years. I can verify this with supporting documentation (upon request only).	Yes	No

## 7: Your current living and financial situation

<b>Living arrangements</b> (Please circle the box/s applicable to you)	Own home	Housing ACT	Private rental	Hospital	Nursing home
	Refuge	Temporary accommodation	Supported accommodation	Other (Please state):	
	Living with parents/siblings	Sharing house with others	Living Alone	Living with spouse and or children	
<b>Income</b> (Please circle either yes or no)	<b>Employment</b> * Full time			Yes	No
	* Part time			Yes	No
	* Supported			Yes	No
	<b>Student</b>			Yes	No
	<b>Centrelink Payment</b>			Yes	No
	<b>Other</b> (please state if yes)			Yes	No

**8: Primary and other significant disability group/s:**

Your Primary disability  
(tick **One** box only)

Your Secondary disability (tick **all**  
other disabilities that affect you)



	<b>Intellectual</b>	
	<b>Specific learning/ADD – other than an intellectual disability</b>	
	<b>Autism, including 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>	



If relevant please provide the name/type/diagnosis of your primary disability	
---	--

## 9: Your Health:

Please list any medical issues that affect your current health and well-being.	
--	--

## 10: How often do you need support to participate in the following life areas?

Please indicate the level of support you require. Tick one column (1-4) for each life area

Life Area	Support Required			
	1 Unable to do or always needs help/support in this life area	2 Sometimes needs help/support in this life area	3 Uses aids or equipment, but does not otherwise need help/support in this life area	4 Does not need any help/support in this life area
A) Self care, eg, personal care				
B) Mobility				
C) Communication, eg; making yourself understood				
D) Interpersonal relationships and interactions				
E) Learning, applying knowledge, and general tasks and demands				
F) Education				
G) Recreation and leisure, and handling money				
H) Domestic Life				
I) Employment				

## Section 2: Current Circumstances

### 11: Disability ACT Funding:

Are you currently in receipt of an Individual Support Package from Disability ACT?		Yes	No
Agency holding funds		Amount (if known)	

### 12: 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

### 13: Do you currently access ANY of the following funded services?

Service	Tick if YES	Hours/week	Service	Tick if YES	Hours/week
A) Advocacy			J) Personal care		
B) Therapy			K) Recreation programs		
C) Case Management/Coordination			L) Day programs / Community Access		
D) Centre-based respite			M) Independence living training		
E) Home based respite			N) Accommodation Support		
F) Other flexible respite			O) Community Transport		
G) Home Help			P) Outreach/in home support		
H) Meals on wheels			Q) Other Please Specify:		
I) Home nursing					

**14: Do you currently rely on members of your family or friends to assist you meet your disability support needs?**

If so please provide details and any comments in relation to this support.

**15: Please provide a general outline of your current circumstances in relation to this application**

(A brief description of life as it is for you now)

**16: Please identify any factors in your life that present a risk to you, others, or your support arrangements**

### **Section 3: Your Goals**

**17: What goals that you are hoping to achieve with additional disability support services.**

**18: Have you started any planning or preparation towards achieving these goals? If so please provide details.**

## Section 4: School Leavers

### 19: Completed School:

I will complete my Year 12 Certificate in December 2008 <b>OR</b>	Yes	No
As at 31 December 2008, I will be 20 years of age, and will have completed my Year 12 studies at Black Mountain School.	Yes	No

**If you have not completed school, you are not eligible for Post School Options (PSO) support.**

### 20: Study/Training:

Will you be undertaking further education or training in 2009?	Yes	No
Will you be studying on a full time basis* (considered to be 75% or more of a full-time course load)	Yes	No
Please provide details		

**\* If you are undertaking full-time training or study in 2009 you will not be eligible for transition or community access services.**

### 21: Employment

Are you able to seek full-time employment (of 30+ hours per week)*	Yes	No
Will you seek work in 2009	Yes	No
Please provide details		

**\*If you commence full-time employment of 30+ hours per week, you will not be eligible for transition or community access services.**

## Section 5: Support Requested

**24: What disability support services will assist you to meet your goals?**

Priority (1,2,3...)	Support requested	How regularly do you need it	Over what period

**25: What difference will these supports make in your life?**

# Agreement and Consent Form

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

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

**Applicant**

Name	
Signature	
Date	

**Guardian (if applicable)**

Name	
Signature	
Date	

**Consent to release information.**

I give consent for Disability ACT to use the information in this application to

- Determine priority for funding
- Negotiate support and service providers
- Plan for unmet need
- Provide advice to other agencies/departments about the support provided.

**Applicant**

Name	
Signature	
Date	

**Guardian (if applicable)**

Name	
Signature	
Date	

**Other persons assisting applicants to complete this form:**

Name	
Agency or relationship to applicant	
Postal address	
Telephone number	
Signature	
Date	

**Thank you for taking the time to fill in this application.**