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PLACEMENT APPLICATION FORM

GENERAL INFORMATION

This Application Form is to be used to apply for the following services which are provided by Community Service Organisations **for Mental Health Services South**:

- **RESIDENTIAL REHABILITATION AND SUPPORTED ACCOMMODATION PROGRAMS:**
  - Richmond Fellowship - *Lindisfarne* 6243 9466 ❒
    - *Glenorchy* 6273 8650 ❒
    - *Rokeby* 6247 7655 ❒
  - Caroline House 6234 5011 ❒
  - Langford Villas 6278 1677 ❒
- **ASPIRE REHABILITATION AND SUPPORT PROGRAM** 6224 5247 ❒
- **ANGLICARE RECOVERY PROGRAM** 6213 3555 ❒

If you require additional information to assist in the application process, please ring the Mental Health Services Area in the appropriate region:

South: 6211-5000 North: 6336 2196 North West: 6434 4070

When completed, all documentation should be enclosed in an envelope marked CONFIDENTIAL and delivered or sent to:

Betsy Floyde
Maximising Recovery Panel – SOUTH
Mental Health Services
329 Main Road, Glenorchy, Tas 7009

Or emailed to: mhs.mrpsouth@dhhs.tas.gov.au

This will allow applications to be assessed by the Maximising Recovery Panel and a determination made as to whether or not the requested services will be provided.
The MRP South meets fortnightly and all applicants or case managers will be informed in writing of the outcomes of this process.

Mental Health Services (MHS), as part of the Department of Health and Human Services (DHHS), collects personal information from you for the purpose of your application to the Maximising Recovery Panel (MRP) and this information will be used by the MRP to determine the appropriate service option. If MHS does not receive all the information required, the MRP may not be able to adequately assess your application.

The service options are provided by Community Service Organisations (CSO's) and MHS will ask for your consent to disclose some or all the information MHS collects to the recommended service option provider (CSO).

Throughout this process, your personal information will be managed by MHS and CSO's in accordance with the Personal Information Protection Act 2004 and you may access your information on request. For further information about DHHS management of your personal information, you can review the personal information protection policy at www.dhhs.tas.gov.au/aboutus/pip.php or MHS can provide you with a copy of the policy.

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A. CONSENT

I, ____(Applicant full name)
Please print clearly

give my consent for an Application to be made to the Maximising Recovery Panel for a Community Service Organisation program option(s).

I have discussed this Application with my Mental Health Case Manager or Designated Clinician, named below;

Name: ____

Address: ____

Contact phone no.: ____________________

and I understand and give consent where applicable, that:

1. Mental Health Services will collect, review, hold and where necessary provide my personal information (including mental health history) to the CSO supplying the service requested in this application. The collection, use and disclosure of this information is governed by the Personal Information Protection Act 2002 (PIP Act).

2. This application will be forwarded to the Maximising Recovery Panel with details of my personal information.

3. The Maximising Recovery Panel will consider my application and will advise me of one of the following outcomes:
   - Recommend to commence orientation with a CSO provider;
   - Recommend service, but placed on a waiting list;
   - Non acceptance but with recommendations made to Case Manager/Designated Clinician.

4. If the Maximising Recovery Panel recommends me for a service option, I give consent for a copy of this Application, to be given to the CSO providing me with the service option.

Applicant ____ / /
Signature

Witness ____ / /
Signature

B. APPLICATION

APPLICANT INFORMATION

Please print clearly

First Name:			
Middle Name/s:			
Surname:			
Street Address:			
Suburb:		**Postcode**	
Date of Birth:		**Age:**	**Gender:** ☐ **M** ☐ **F**
Telephone:		**Mobile:**	
Language of Communication		**UR Number** *(if known)*	

Legal Status e.g. IO,CCO,CTO	
Guardianship Orders *(state if any)*	
Person responsible *(if other than self)*	
Mental Health Diagnosis	
Responsible Case Manager/ Clinician	
Community Mental Health Team	
General Practitioner	

REFERRER INFORMATION

Application made by *(Referrer)*		
Relationship to Applicant		
Referrer's Contact details	**Phone:**	
	Email:	
Referrer's Signature		
As Referrer, do you wish to attend the MRP meeting where this application will be discussed? ***Approx. 10 mins.***	☐**Yes**	☐**No**
If you answered 'No' to the above, would you like to be contacted by phone during the meeting.	☐ **Yes**	☐ **No**

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COMMUNITY SERVICE OPTIONS *Please tick the service for which you are applying:*	
Residential Rehabilitation & Supported Accommodation Program *Richmond Fellowship (please indicate Lindisfarne/Glenorchy/Rokeby)* *Langford Villas* *Caroline House*	☐ ☐ ☐
ASPIRE Rehabilitation & Support Program	☐
Anglicare Recovery Program (Formerly Package of Care)	☐
We ask that clients visit the service requested before submitting the application. Has the client visited?	☐ Yes ☐ No
Which CSO(s) did he/she visit?	

Please Tick the appropriate boxes below and provide the Panel with detailed information where indicated.

REHABILITATION & SUPPORT NEED GOALS

DAILY LIVING SKILLS	REQUIRES PROMPTS	IS INDEPENDENT
Cooking		
Clothes washing		
House cleaning		
Budgeting		
Banking		
Transport		
Please state any difficulties the client has in this area and what they are interested in learning	*Please state aims:*	
SOCIAL RELATIONSHIPS	**YES**	**NO**
Interested in activities with others		
Interested in joining with groups		
Type of leisure activities client is interested in	*Please state:*	
WORK AND EDUCATION	**YES**	**NO**
Has worked in the past		
Requires pre-work skills		
Has a short-term goal to work		
Type of work/training desired		

CLIENT EXPECTATIONS OF THE APPLICATION

If you require more space, please attach another separate sheet to this application.

If the applicant is a client of MHS please attach a current copy of a Mental Health Risk Assessment if available.

ALL REFERRERS MUST COMPLETE THE FOLLOWING:

1	2	3	4
Low level of risk			Significant Difficulties

Using the rating scale above, please rate the following from 1-4 according to possible risk. If an item is rated 3 or 4, provide further details in the adjacent column or on the next page.

LEVEL OF RISK 1 - 4		DETAILS
	Medication adherence issues	
	Alcohol and drug issues	
	High relapse frequency	
	Suicide Risk	
	Harm to others	
	Self Harm	
	Harm from Others	
	Care of self	
	Daily living skills	
	Level of support needed	
	Housing Issues	
	Self esteem/confidence	
	Vocational Issues	
	Parenting Issues	

Other risk issues - please specify:
Please use this space to provide more detail around risk issues which were rated 3-4
Special considerations: e.g. Non-English speaking background, Dependents, Significant others, physical or intellectual disability, Acquired Brain injury

C. ADDITIONAL INFORMATION

Current medication, dosage and frequency
Current therapy / programs / activities

INPATIENT ADMISSIONS *(Please include first admission and last four only)*

Date	Length of admission (if known)	Discharge diagnosis (if known)

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CHECKLIST FOR CLIENT & REFERRER	
Please tick when completed	
Client and witness have signed the Consent Form (Page 2)	☐
Client has completed personal details (Page 3)	☐
Copy of MHS Risk Assessment (attached if available)	☐
Referrer has signed Application Form (Page 3)	☐
SUPPORTING DOCUMENTATION ATTACHED *(Optional, but no more than 3 Documents)*	
Please list:	

Please enclose in an envelope marked CONFIDENTIAL and send to:

Maximising Recovery Panel-South
329 Main Road
Glenorchy, Tas. 7009

or Email to: mhs.mrpsouth@dhhs.tas.gov.au

For further information or clarification please call Betsy Floyde on 6211 5014.