

Acquired Brain Injury: Slow To Recover Program

Application Form

This form is to apply for Acquired Brain Injury: Slow to Recover services.

Applicants and families should understand that by completing this application, it does not guarantee a service. The ABI STR Program has a panel of independent rehabilitation practitioners that will decide on the merit of this application for slow to recover services taking into account the applicants eligibility, priority and the resources available to provide services.

Please complete the following questionnaire and return to:

**Disability Services Manager
ABI STR Program
Bunurong Community Care
4th Floor, 229 Thomas Street
DANDENONG VIC 3175**

Questionnaire:

1. Applicant's Surname

2. Applicant's First Names

3. Date of birth

4. Gender (M/F)

Date of birth of primary care giver.
(If the Primary carer has total responsibility for the care of the client)

5. Department of Human Services Region of Origin

6. Current residence/location of applicant

7. Address

8. **Country of Birth**

9. **Are you of Australian Aboriginal and/or Torres Strait Islander origin?**
(X appropriate box)

- No, not Aboriginal or Torres Strait Islander
- Yes, Aboriginal
- Yes, Torres Strait islander
- Yes, Aboriginal and Torres Strait Islander

10. **Cause of ABI**

11. **Date ABI Occurred**

12. **Has the applicant been assessed as needing long-term nursing care and/or eligible for Commonwealth- funded nursing home services?**

Yes No

13. **Has the applicant undertaken any form of post acute rehabilitation?**

Yes No

If yes please include details in the client history.

14. **Does the applicant have parenting responsibilities for children less than 15 years of age?**

Yes No

If yes please include details in the client history.

15. **Person filing application details.**

Name

Address **Phone:**

Relationship to person with ABI.

16. **Attention: Please attach a brief history of the client's circumstances, including how they acquired their brain injury and details of their current physical, cognitive and medical status.**

Acquired Brain Injury, Slow To Recover (ABI STR) Program

Consent form

(Please cross out italics if not applicable)

*I hereby give my consent,
As guardian or responsible adult I hereby give consent on behalf of,*

.....
(Name of the client)

- for the ABI STR Program to obtain any medical information it deems necessary to make an assessment for ABI STR services.

(optional - cross out if you do not wish personal details to be transferred by internet or electronic media)

- *and medical assessments and information may be electronically sent via the Internet to all relevant people involved in the care and the provision of such services.*

I have been provided with relevant information regarding the ABI:STR Program and I understand that this application is part of a process to determine eligibility and does not guarantee that services will be provided.

All information will be provided with the strictest confidentiality in accordance with Southern Health privacy and confidentiality policy and procedures.

Person giving consent/

Guardian or responsible adult
Print Name Signature

Relationship to recipient eg.

(Please circle one as appropriate)

- Self
- Wife
- Husband
- Legal Guardian
- Parent
- Sibling
- Other – Please state

Address of person giving consent.

.....

Contact Phone Number

Work:

Home:

Acquired Brain Injury, Slow to Recover (ABI, STR) Program

Declaration of Compensation

Please place an X in the appropriate Yes/No response box.

1. Name of potential recipient of Slow to Recover services.

.....

Print name:

2. Has the client ever received a compensation payment for their injury?

Yes No (Go To Q4)

If Yes, please state the nature of the compensation and the injury.....

.....

.....

3. If the client has previously received a compensation payment, did the terms of the settlement specify it to be used for personal care/ accommodation support, equipment or housing modifications or for any other specific use?

Yes No

If Yes, please attach details and documentation of the client's settlement.

4. Has the client ever made or intends to make a claim for compensation or damages for their injury.

Yes No

5. Is the client eligible for or receiving personal care/accommodation support or other support services from another source? (eg Veteran's Affairs, Transport Accident Commission or Workcover).

Yes No

If Yes, please provide details.....

.....

Declaration:

I hereby acknowledge as the recipient of ABI STR services or as the guardian or the adult responsible for the above named recipient's affairs, that should I or they apply for and receive compensation in relation to my/their acquired brain injury then the following conditions apply:

- 1. Southern Health must be notified of any such compensation proceedings.***
- 2. Southern Health may claim repayment of funds advanced for services previously rendered and will rely on this acknowledgment in any recovery proceedings legal or otherwise.***

.....
Print Name: Self, guardian, responsible adult *Signature*

Note:

- A) You may wish to seek independent legal advice prior to signing this agreement.**
- B) You should also notify your solicitor that there would be a requirement to repay funds advanced by the Southern Health from any compensation received.**