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HASI Housing and Accommodation Support Initiative NSW Government initiative

HASI Orana and Western NSW Application and Referral Form

Before starting the referral please ensure you meet the following eligibility criteria for making a referral as below:

- *Psychiatric Diagnosis / functional impairment assessed by mental health professional:* □ *Yes* □ *No*
- *Client willing to undertake HASI support* □ *Yes* □ *No*
- *Client provided informed consent* □ *Yes* □ *No*

Please consult with HASI provider if the answer is 'no' to any of these questions

Level of Support Required (please select one):

HASI Low Support □ **3 – 5 hours/week** Dubbo, Wellington, Lighting Ridge, Walgett, Broken Hill, Mudgee	**HASI High Support** □ **up to 35 hours/week** Dubbo	**HASI in the Home (Low and Medium support)** □ Coonamble, Coonabarabran, Dubbo	**Aboriginal HASI High, Medium-High** □ Dubbo, Wellington, Walgett, Lighting Ridge, Coonabarabran, Coonamble, Bourke
Fax to:	**Fax to:**	**Fax to:**	**Fax to:**
MISSION AUSTRALIA together we stand	MISSION AUSTRALIA together we stand	MISSION AUSTRALIA together we stand	MISSION AUSTRALIA together we stand
Mudgee: 02)6372 6039 Walgett: 02)6828 3620 Dubbo/Wellington: 02)6884 8527 Broken Hill: 08)8087 4904	Dubbo/Wellington: 02)6884 8527	Coonabarabran: 02)6842 1057 Dubbo: 02)6884 8527 Coonamble: 02)6822 2355	Coonabarabran: (02)6842 1057 Walgett/Lighting Ridge (02)6828 3620 Dubbo: (02)6884 8527 Coonamble: (02)6822 2355 Bourke: (02) 6870 1036

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Source of referral:

Date of referral: ....

Name: .... Telephone: ....

Email: .... Mobile: ....

Agency/Organisation: ....

Applicant Details:

MRN……………………………………………MHOAT Number (if known)……………………………….

First Names .... Last Name ....

Other preferred names: ....

Address: .... Post Code: ....

Telephone: .... Mobile No: ....

Date of Birth: .... Male ☐ Female ☐

Country of Birth: ....

Cultural Identity:

Does client identify as being of:

☐ Aboriginal Torres Straight Islander - Country/nation of birth: ....

☐ Cultural & Linguistically Diverse Background - Country/nation of birth: ....

Main language spoken at home ....

Interpreter required? ☐ Yes ☐ No List Details ....

Financial Management and Guardianship

☐ Independent ☐ T&G (financial) ☐ T&G (guardian) ☐ Carer/Family

Source of income: ☐ DSP ☐ Newstart ☐ Youth Allowance

☐ Other (provide detail) ....

CRN (if applicable)…………………………………………………….

Contact details: ....

Accommodation Status:

☐ HNSW/CHP ☐ Private Rental ☐ In Hospital ☐ Own Home ☐ Boarding House

☐ Homeless ☐ Family/friends ☐ OPG ☐ Other (specify)..................................

Housing provider: ....

Contact Details: ....

Have they been informed of HASI referral? ☐ Yes ☐ No

Does the client qualify for public housing in NSW? ☐ Yes ☐ No

Please list any issues placing the tenancy at risk:

☐ History of Consumer Tenancy & Trader Tribunal action / No. in last 2 years: ....

☐ Nuisance and Annoyance Complaints / No. in last 2 years: ....

☐ Probationary Tenancy

☐ High turnover in housing / No. properties in last 2 years: ....

☐ History of homelessness

☐ Domestic Squalor/poor property care/property damage

☐ Other: ....

....

Describe any current housing issues or unmet accommodation support needs:..........

....

....

Existing Supports and Services:

Does the client have a care coordinator at an Area Mental Health Service? ☐ Yes ☐ No

Name: ....

Service: ....

Telephone: .... Mobile No: ....

Email: ....

General Practitioner: ....

Contact Details: ....

Details of support received: ....

....

Psychiatrist: ....

Contact Details: ....

Details of support received: ....

....

Does the client have a carer? ☐ Yes ☐ No

Does the carer live with the client? ☐ Yes ☐ No

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Please outline all other service and agencies involved with the client:

Agency/Service	Type of support provided	Contact details

How can HASI best support the client: ....

....

....

....

....

Predicted support hours per week: ....

Health Information:

Primary Diagnosis: (tick one)

- □ Schizophrenia
- □ Bipolar Disorder
- □ Depression
- □ Anxiety
- □ Personality Disorder
- □ Schizo-affective
- □ Other (specify)

....

....

Secondary Diagnosis: (tick one)

- □ Schizophrenia
- □ Bipolar Disorder
- □ Depression
- □ Anxiety
- □ Personality Disorder
- □ Schizo-affective
- □ Other (specify)

....

....

Other co-existing factors impacting on mental illness: (tick all that apply)

- □ Intellectual Disability
- □ Substance Abuse
- □ Physical disability
- □ Physical health issues
- □ Acquired Brain injury
- □ Other (specify)

....

....

Other medical conditions: ....

....

....

....

Psychiatric History

Brief History: ....

....

....

....

Has the application had an inpatient stay in the past 12 months ☐ Yes ☐ No

Forensic History:

☐ Yes ☐ No

Please give details: ....

....

Are there any outstanding fines? ....

....

Is there a CTO in place? ☐ Yes ☐ No Date for review: ....../....../......

Substance abuse and addiction concerns:

Are there substance abuse concerns? ☐ Yes ☐ No ☐ Previous history

☐ Illegal drug ☐ alcohol use ☐ tobacco ☐ caffeine ☐ over the counter

☐ Misuse of prescription medication ☐ gambling ☐ other (specify below)

Describe current issues and history: ....

....

....

....

Self Harm and suicide attempts:

☐ Yes ☐ No ☐ Previous History

....

....

....

Violence and Aggression:

☐ Yes ☐ No ☐ Previous History

……

……

……

Risk Taking Behaviours:

☐ Yes ☐ No ☐ Previous History

……

……

……

Other Behavioural Concerns:

☐ Yes ☐ No ☐ Previous History

……

……

……

Please also ensure any recently completed, relevant, standardized assessment tools, OT assessments and discharge summaries are attached at the time of referral.

Has the applicant been involved in completing this form? ☐ Yes ☐ No

Please contact your Local office if you require any further information and for general enquires:

Dubbo (Regional Office)
110-114 Macquarie Street, PO Box 2043 Dubbo NSW 2830 Tel: (02) 6884 8526
Coonabarabran
56a Cassillis Street, PO Box 55 Coonabarabran NSW 2357 Tel: (02) 68421087
Coonamble
87 Castlereagh Street, PO Box 149 Coonamble NSW 2829 Tel: (02) 6822 2311
Mudgee
154 Church Street, PO Box 55 Mudgee NSW 2850 Tel: (02) 6372 7417
Walgett
68 Fox Street, PO Box 306 Walgett NSW 2832 Tel: (02) 6828 3570
Broken Hill
125 Chloride Street, PO Box 264, Broken Hill NSW 2880 Tel: (08) 8088 6719
Bourke
24 Richard Street (Po Box 611) Bourke NSW 2840, Tel: (02) 6872 4894

The Privacy Act requires the applicant to sign this form giving their consent for the release of their information and details.

CONSENT

I, ___________________________ give support for this referral to HASI and give consent for HASI support providers to seek/share relevant information with the following people/services/ organisations concerning matters related to this application for it to be considered:

- Relevant Local Health District
- Relevant Housing Providers
- Family members/carers (if applicable)
- Other HASI services
- Other services outlined in this referral
- De-identified statistics for programme evaluation for the period of this intake process.

I also give my consent to the Accommodation Support Provider to keep a record of my referral and to contact the person or agency referring to update any information and to see if I am still interested in HASI support.

Signed: _____________________________ Date: ______/_____/_____

The referrer agrees that all information submitted in this referral is an accurate reflection of the client's support needs, is correct with no information withheld and is necessary for the supported accommodation organisation to fulfil its duty of care to clients, staff and other partner agencies.

REFERRER'S SIGNATURE: .... Date: ___/___/___

REFERRER'S STAMP IF AVAILABLE: