SENIORS ASSISTANCE FUND

A PROGRAM FUNDED BY THE CITY OF MELVILLE

The following information is necessary for statistical reporting of services provided through SAF funds. An ID number will be used to ensure confidentiality.

Referral Source

If Agency Referral - Agency to Complete

Date of Referral		Contact Person	
Agency Name		Phone No.	
Agency Address			
Fax No.		Email	

If Self Referral - Care Options to Complete

Date of Referral		Contact Person	
Agency Name		Phone No.	
Agency Address			
Fax No.		Email	

Consent for Information Sharing

It may be necessary to provide information about you to other individuals and agencies to ensure the most appropriate community care and support services are provided to you. You can withdraw your consent to the sharing of your personal information at any time.

Consent Given by Client ☐ Yes ☐ No

Client Details

Name		Phone	
Address		Post Code	
Date of Birth		Age in Years	
Country of Birth		Aboriginal or Torres Strait Islands	Yes ☐ No ☐
Language Spoken		Lives Alone ☐ Family ☐ Others ☐	
Does the SAF Client have a Primary Carer?		Yes ☐ No ☐	
Lives with Primary Carer?		Yes ☐ No ☐	

Income Level			
☐ Level 1 - Annual taxable income of $0 - $50,000 (single), or More than $50,000 (couple)?			
☐ Level 2 - Annual taxable income of $0 - $80,000 (single) or More than $80,000 (couple)?			
Accommodation Status			
Own Home ☐	Private Rental ☐	Public Rental ☐	Other ☐
Give brief details of Clients circumstances / health /special needs etc.			
Have you accessed SAF before?			
Other services being provided to the person/ family			
Assistance Required			
☐ **Assessment**			
☐ Occupational Therapy	☐ Physiotherapy		
☐ **Equipment**			
☐ External Rails	☐ External Ramps	☐ Care Link Alarm Installation	
☐ Internal Rails - Where exceptional circumstances			
☐ Hire or purchase of non fixed equipment and aids - Where exceptional circumstances			
☐ Other			
☐ **Gardening / Home Maintenance**			
Description (Please provide details of services required, expected hours and cost.)			

☐ **Respite**		
☐ In Home	☐ Residential Respite - Venue	
Start and end date		
Daily or hourly cost	$	
☐ **In Home Services e.g. personal care, domestic assistance**		
Type (estimate time required per service)		
Frequency: ☐ One Off ☐ Daily ☐ Weekly ☐ Fortnightly Preferred Day: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun		
Start and end date		
☐ **Other**		
Agency/ facility/ contractor to provide the service (If unsure contact the SAF coordinator)		
SAF Client Contribution (Contribution can be waived in exceptional circumstances)		$
Total Funding being requested		$

Please list all sources of assistance you have contacted prior to accessing the SAF Funds.

Agency	Reason for Non-Acceptance

On the completion of the SAF services, what other arrangements have been made if further services or support is required?

Extra details if required:

Please return this form to
SAF Coordinator
Care Options
PO Box 711
Rockingham WA 6968

Phone: 9550 7888
Fax: 9527 6372
Email: SAF@careoptions.org.au