protecting your privacy

The information collected on this form will be used for the purposes of determining acceptance into the Commonwealth Psychosocial Support Program (CPS) and to assist in the delivery of services. This information will not be released, disclosed to any third party without your consent or unless required by law. You may refuse to provide us with some or all of your personal information, however, this may limit the ways in which we can interact with you, including providing you with our services.

You can access our Privacy Policy at <http://www.stepsgroup.com.au/privacy-policy>

|  |  |
| --- | --- |
| **Commonwealth Psychosocial Support Program (CPS)** | The CPS program is intended to support Consumers with a severe mental illness not currently accessing the National Disability Insurance Scheme (NDIS). The program aims to strengthen the capacity of Consumers to live independently, safely, and productively in their community, form meaningful connections in a supportive environment, and reduce the need for acute care. |

referred by

|  |  |
| --- | --- |
| Name |  |
| **Position** |  |
| **Organisation** |  |
| **Email** |  |
| **Phone** |  |
| **Date** |  |

referRal details

|  |  |
| --- | --- |
| Currently in Hospital  | [ ]  **Yes** [ ]  **No** |
| Currently in the Community  | [ ]  **Yes** [ ]  **No** |
| Has a risk assessment been completed?  | [ ]  **Yes** [ ]  **No** |
| Adult Guardian or Public Trust appointed (please specify) | [ ]  **Yes** [ ]  **No** |
| Is the individual under a Forensic Order | [ ]  **Yes** [ ]  **No** |

Applicant details

|  |  |  |  |
| --- | --- | --- | --- |
| First Name |  | Last Name |  |
| **Date of Birth** |  | [ ]  Male [ ] Female [ ] Unspecified |
| **Phone** |  | **Email** |   |
| **Address** |  |
|  |
| **Carer/Support Person Name (where required)** |  | **Relationship** |  |
| **Phone** |  | **Email** |   |

Is the carer or support person involved in the individual support? YES [ ]  NO [ ]

Is the client aware of the Referral?  YES [ ]  NO [ ]

CULTURAL REQUIREMENTS

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|   |
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­­­­­­­­­­­­­­­­­­­­­­­­­­­­Disability/mental health details

please identify any alerts, risks and mitigating factors. (this can be incorporated in the email if needing more space)

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Reason(s) for Request

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current involvement with other agencies/professionals

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|  |

office use only

Referral accepted [ ]  Referral declined [ ]

|  |  |  |  |
| --- | --- | --- | --- |
| Referral decision by: Name |  | Date |  |

Reason

|  |
| --- |
|  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| Letter of Acceptance/Decline Completed  |  | Date |  |