TAILEM BEND COMMUNITY CENTRE
COMMONWEALTH HOME SUPPORT PROGRAM (CHSP)
MURRAY MALLEE COMMUNITY PASSENGER NETWORK (MMCPN)

This registration form is also a Care Plan to include a fall risk assessment, as requested by the Federal Government

PERSONAL DETAILS				
Title	First Name	Middle Name	Surname	Known As
Email Address		Date of birth	Mobile Number	Home Number
Number / Street			Town	
State / Post Code			Postal Address (If different)	
Gender: Male | Female | Not Stated | LGBTIQA+ (Lesbian Gay Bisexual Transgender Intersexual Questioning Asexual)				
Education - highest level reached:				

PERSONAL DETAILS (CIRCLE YOUR ANSWERS)
Marital Status: Single | Divorced | Married | De facto | Never Married | Separated | Widowed
Living Arrangements: Couple | Couple with Dependent(s) | Group(related adults) | Homeless/No household | Live Alone | Other
Accommodation Setting: Owned | Private Rental | Independent Unit | Emergency Accommodation | Boarding House | Other
Homeless Indicator: If you are homeless, are you at risk? Yes No

ETHNICITY DETAIL (CIRCLE YOUR ANSWERS)
Country of Birth: Australia Other:
Are you from a culturally and linguistically diverse (CALD) background? Yes No
Interpreter Required? Yes No
Main Language spoken at home: English Other:
Indigenous Status: Yes | No | Not Stated | Aboriginal Not Torrens Strait Islander | Torrens Strait Islander Not Aboriginal

MY AGE CARE DETAILS					
My Age Care ID:					
Medicare Number:					
Pension Number:	Pension Type: Aged	Disability	other		
My Age Care package level	CHSP	Level 1	Level 2	Level 3	Level 4
Does the package include transport?	Yes	No			

OR DISABILITY AND NDIS DETAILS	
Disability Pension Number:	NDIS Number:
Medicare Number:	
Are you on a Disability Support Pension, transitioning to NDIS?	Transition Date:
Are you on a Disability Support Pension wanting to go onto NDIS?	Yes No
Do you need support with NDIS application?	Yes No

COVID VACCINATION RECORDS (CIRCLE YOUR ANSWERS)
AstraZeneca | Moderna | Pfizer
Dose 1 | Dose 2 | Booster 1 | Booster 2 | Booster 3 |

TRANSPORT (CIRCLE YOUR ANSWERS)			
Do you require assistance with transport?	Yes	No	
Do you own a car?	Yes	No	
Do you have a current driver's licence?	Yes	No	With Restrictions
Do you have family/friends that help with transport?	Yes	No	Sometimes
Do you require a companion to travel?	Yes	No	Sometimes
Can you get on/off a bus?	Yes	No	With assistance

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INCOME / ENTITLEMENTS DETAIL (CIRCLE YOUR ANSWERS)

Main Source of Income:

Disability Support Pension | Aged Pension or Benefit
Unemployment Pension | Individual Funding | Other Income

DVA status:

DVA Gold card holder | DVA White card holder | Not a DVA card holder | Other

Employment Status:

Caring | Parenting | Casual | Part time | Full Time | Not in paid employment | Not working/not looking for work

SUPPORT NEEDS/FUNCTIONAL STATUS/CARE AND MEDICATION

Can You Complete The Following Tasks Without Assistance? (Circle Your Answers)

Self-care – personal hygiene	Yes	Sometimes	No	Comment:
Mobility / Walking	Yes	Sometimes	No	Comment:
Communication with people	Yes	Sometimes	No	Comment:
Community engagement	Yes	Sometimes	No	Comment:
Shopping	Yes	Sometimes	No	Comment:
Domestic / household cleaning	Yes	Sometimes	No	Comment:
Gardening and yard duties	Yes	Sometimes	No	Comment:
Learning / including technology	Yes	Sometimes	No	Comment:
Transport	Yes	Sometimes	No	Comment:
Medication	Yes	Sometimes	No	Comment:
Bathing or Showering	Yes	Sometimes	No	Comment:
Dressing	Yes	Sometimes	No	Comment:
Eating	Yes	Sometimes	No	Comment:
Toileting	Yes	Sometimes	No	Comment:
Memory problem or confusion	Yes	Sometimes	No	Comment:
Behavioural concerns	Yes	Sometimes	No	Comment:

Falls: (Circle Your Answers)

Are you at risk of Falls? Yes No
When was the last time you fell over or tripped? Month _ _ | Year 20_ _

Challenging Behaviour: (Circle Your Answers)

High level of support required | Medium level of support require | Low level of support required | No support required

Dementia: Yes No

Other Disabilities:

Autism | Intellectual | Deaf/Blind (dual sensory) | Hearing (sensory)
Mobility | Physical | Speech (sensory) | Vision (sensory) | Other

Requires wheelchair access?	**Yes**	**No**	**If yes, please provide details:**
Do you make use of an aid to assist with mobility?	**Yes**	**No**	**If yes, please provide details:**

Please list your medications: (or attach your chemist list) and any relevant medical conditions.

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EMERGENCY CONTACTS / OTHER PEOPLE / CARE INFORMATION **Please note we must have a minimum of two emergency contact details for each consumer**	
Name Address Phone Number Relationship Contact in an emergency Yes No	Name Address Phone Number Relationship Contact in an emergency Yes No
Doctor / Specialist:	Name: Phone number:

CHSP COORONG SERVICES **What services would you like to receive (Circle Your Answers)**				
Home Maintenance	Gardening	Gutter / Windows		Other:
Goods and Assistive Equipment	Kitchen Aids	Bed Sticks	Walker	Other:
Modification	Grab Rails	Bathrooms	Kitchens	Other:
Group Activities	Classes	Bus Trips		Other:
Social Support Individual	Regular Phone chats	Updates on outings and home maintenance		

GOALS/REABLEMENT
What is important to me:
What is something I would really like to achieve future goals or experiences?

CONSENT TO SHARING PERSONAL INFORMATION (Circle Your Answers)					
Do you consent to TBCC/MMCPN (in accordance with the Information Sharing Guidelines (ISG) sharing information with other CHSP/NDIS/MMCPN Or Health services providers (if required for Government reporting) to manage/mitigate risk to your health?				**YES**	**NO**
I consent for photos to be shared: (Circle Your Answers)	**All Listed**	**Social Media**	**Promotion**	**None**	

Copies of the following documents can be requested by contacting TBCC/MMCPM Staff (Circle Your Answers)		
HAVE YOU READ or SIGNED INFORMATION	**Yes**	**No**
CHSP MMCPN Booklet https://www.tbcc.org.au/chsp-hacc/	**Yes**	**No**
Aged Care Quality Standards - https://www.agedcarequality.gov.au/providers/standards	**Yes**	**No**
Charter of Aged Care Rights – provided below	**Yes**	**No**
Do you have an Advance Care Directive?	**Yes**	**No**
If not, would you like some information sent to you?	**Yes**	**No**

TBCC / MMCPN Information **How did you find out about the services offered by the Tailem Bend Community Centre?** **(Circle Your Answer)**					
Family	**Friends**	**Radio / Newspaper**	**Service Provider**	**My Age Care**	**Other**

Date: Signature:

I have the right to withdraw consent at any time by notifying the Tailem Bend Community Centre on 08 8572 3513

We appreciate you taking the time to complete this form.

Please return this form to:
Po Box 203, Tailem Bend, S.A. 5260
or The Tailem Bend Community Centre, 141 Railway Terrace, Tailem Bend, S.A. 5260
or email info@tbcc.org.au

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Australian Government
Department of Health

Australian Government
Aged Care Quality and Safety Commission

Charter of Aged Care Rights

I have the right to:

1. Safe and high quality care and services;
2. Be treated with dignity and respect;
3. Have my identity, culture and diversity valued and supported;
4. Live without abuse and neglect;
5. Be informed about my care and services in a way I understand;
6. Access all information about myself, including information about my rights, care and services;
7. Have control over and make choices about my care, and personal and social life, including where the choices involve personal risk;
8. Have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;
9. My independence;
10. Be listened to and understood;
11. Have a person of my choice, including an aged care advocate, support me or speak on my behalf;
12. Complain free from reprisal, and to have my complaints dealt with fairly and promptly;
13. Personal privacy and to have my personal information protected;
14. Exercise my rights without it adversely affecting the way I am treated.
15. I have the right to withdraw consent at anytime by notifying the Tailem Bend Community Centre.

Consumers

Consumers have the option of signing the Charter of Aged Care Rights (the Charter). Consumers can receive care and services even if they choose not to sign.
If a consumer decides to sign the Charter, they are acknowledging that their provider has given them a copy of the Charter, and assisted them to understand:

- information about consumer rights in relation to the aged care service; and
- information about consumer rights under the Charter.

Providers

Under the aged care law, providers are required to assist consumers to understand their rights and give each consumer a reasonable opportunity to sign the Charter. Providers must give consumers a copy of the Charter that sets out:

- signature of provider's staff member;
- the date on which the provider gave the consumer a copy of the Charter; and
- the date on which the provider gave the consumer (or their authorised person) the opportunity to sign the Charter;
- the consumer (or authorised person)'s signature (if they choose to sign); and
- the full name of the consumer (and authorised person, if applicable).

The provider will need to retain a copy of the signed Charter for their records.

If you agree with the Charter of Aged Care Rights, please sign below:

Consumer	Provider
Consumer or authorised person's signature (if choosing to sign)	Signature and full name of provider / staff member Denise McLoughlin, CHSP Project Officer Samantha Hicks, MMCPN Coordinator
Full name of consumer	_ _ / _ _ / 20_ _
Full name of authorised person (if applicable)	Date on which the consumer (or authorised person) was given a copy of (and signed) the Charter
Date _ _ / _ _ / 20_ _	_ _ / _ _ / 20_ _