



TAILEM BEND COMMUNITY CENTRE INC (TBCC)

Commonwealth Home Support Program (CHSP)
Community Transport South Australia (CTSA)

This form functions a Care Plan and Falls Risk Assessment, in accordance with Australian Government requirements.

CONTACT DETAILS				
Title	First Name	Middle Name	Surname	Known As
Address: Number & Street Town & Postcode			Postal Address (if different from physical address)	
Telephone 1		Telephone 2 Mobile		
Email Address			Preferred contact method	

PERSONAL DETAILS (please tick your answers)	
Date of birth	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> intersex or indeterminate <input type="checkbox"/> Nonbinary <input type="checkbox"/> Not stated or inadequately described <input type="checkbox"/>
Client status: Care recipient <input type="checkbox"/> Carer <input type="checkbox"/> If yes to carer, are you paid <input type="checkbox"/> or unpaid <input type="checkbox"/>	
Marital status: Single <input type="checkbox"/> De facto <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Never Married <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/>	
Living arrangements: Lives Alone <input type="checkbox"/> Couple <input type="checkbox"/> Couple with Dependent(s) <input type="checkbox"/> Group (related adults) <input type="checkbox"/> Homeless/No household <input type="checkbox"/> Other <input type="checkbox"/>	
Accommodation setting: Owned <input type="checkbox"/> Private Rental <input type="checkbox"/> Independent Unit <input type="checkbox"/> Emergency Accommodation <input type="checkbox"/> Boarding House <input type="checkbox"/> Other <input type="checkbox"/>	
Homeless indicator: If you are homeless, are you at risk? Yes <input type="checkbox"/> No <input type="checkbox"/>	

ETHNICITY DETAIL (please tick)	
Indigenous status: Yes <input type="checkbox"/> No <input type="checkbox"/> Not Stated <input type="checkbox"/>	If Yes: Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander <input type="checkbox"/>
Country of birth: Australia Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	
Language spoken at home: English Yes <input type="checkbox"/> No <input type="checkbox"/> Other:	Interpreter Required? Yes <input type="checkbox"/> No <input type="checkbox"/>
Communication method: Spoken language (effective) <input type="checkbox"/> Child aged under five years (not applicable?) <input type="checkbox"/> Little, or no effective communication <input type="checkbox"/> Other effective non spoken communication <input type="checkbox"/> Sign language (effective) <input type="checkbox"/>	
Are you from a culturally and linguistically diverse (CALD) background? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you identify as LGBTIQ? Yes <input type="checkbox"/> No <input type="checkbox"/> Other please state	
Highest level of education reached:	

INCOME / ENTITLEMENTS (please tick))
Employment status: Caring <input type="checkbox"/> Parenting <input type="checkbox"/> Casual <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Not in paid employment <input type="checkbox"/> Not working/not looking for work <input type="checkbox"/>

Office use only

Client status

CHSP/CTSA ↑ 65yrs ☐ CHSP HCP/SAH ☐ CHSP ATSI ↑45yrs ☐ NDIS ☐ CTSA ↓65yrs ☐ CND ☐ Commercial ☐

Please circle

Main source of income or government pension/benefit? (please tick)			
Age Pension or benefit <input type="checkbox"/> Austudy Payment <input type="checkbox"/> Carer Allowance <input type="checkbox"/> Carer Payment <input type="checkbox"/> Disability Support Pension <input type="checkbox"/> Disaster Recovery Allowance <input type="checkbox"/>	Employment income <input type="checkbox"/> Energy Supplement <input type="checkbox"/> Farm Household Allowance <input type="checkbox"/> Income Support Supplement <input type="checkbox"/> Invalidity Service Pension <input type="checkbox"/>	Job Seeker Payment <input type="checkbox"/> Parenting Payment <input type="checkbox"/> Pharmaceutical Allowance <input type="checkbox"/> Rent Assistance <input type="checkbox"/> Special Benefit <input checked="" type="checkbox"/> Unemployment pension <input type="checkbox"/>	Veteran payment <input type="checkbox"/> Youth Allowance <input type="checkbox"/> Other (please specify) <input type="checkbox"/>
Pension number:			
Department of Veteran Affairs (DVA) status: Not a DVA card holder <input type="checkbox"/> DVA White card holder <input type="checkbox"/> DVA Gold card holder <input type="checkbox"/> Other: <input type="checkbox"/>			

CARE AND SUPPORT (please tick)	
Challenging Behaviour: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes , what level of support do you require: High level <input type="checkbox"/> Medium level <input type="checkbox"/> Low level <input type="checkbox"/> None <input type="checkbox"/>	
Other information: Has Dementia <input type="checkbox"/> Receiving palliative care <input type="checkbox"/> Requires wheelchair access <input type="checkbox"/> Has chronic condition <input type="checkbox"/>	
Has Advanced Care Directive (ACD): Yes <input type="checkbox"/> No <input type="checkbox"/> Location of ACD: Name and contact of registered supporter (advocate)	
If you do not have an ACD, would you like some information sent to you? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Primary disability:	
Other disabilities: Autism <input type="checkbox"/> Intellectual <input type="checkbox"/> Deaf/Blind (dual sensory) <input type="checkbox"/> Hearing (sensory) <input type="checkbox"/> Mobility <input type="checkbox"/> Physical <input type="checkbox"/> Speech (sensory) <input type="checkbox"/> Vision (sensory) <input type="checkbox"/> Other:	
Allergies: Yes <input type="checkbox"/> No <input type="checkbox"/>	Details:
Medications (please list or attach your chemist list): 	

EMERGENCY CONTACTS / OTHER PEOPLE / CARER INFORMATION	
Please note we must have a minimum of two emergency contact details for each client	
Emergency contact 1	Emergency contact 2
Name Address Phone Number Relationship Email	Name Address Phone Number Relationship Email
Doctor	Specialist
Name: Phone number:	Name: Phone number:

TRANSPORT (circle your answers)	
How often do you usually require transport assistance?	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Fortnightly <input type="checkbox"/> Monthly <input type="checkbox"/> Occasionally <input type="checkbox"/>
What barriers prevent you from using existing public transport options?	No options available <input type="checkbox"/> Cost <input type="checkbox"/> Physical accessibility <input type="checkbox"/> Routes / scheduling <input type="checkbox"/> Other <input type="checkbox"/> (please specify)
Have you used TBCC - Community Transport South Australia (CTSA) before?	Yes <input type="checkbox"/> (please specify location) No <input type="checkbox"/>

What days and times do you usually need transport assistance? <i>(Please specify)</i>	
What trip purposes are most important to you?	Medical <input type="checkbox"/> Social <input type="checkbox"/> Shopping <input type="checkbox"/> Other (please specify)
What type of vehicle accessibility is important to you?	Sedan <input type="checkbox"/> SUV <input type="checkbox"/> Bus <input type="checkbox"/> Wheelchair accessible <input type="checkbox"/>
Are you eligible for concessions?	Pension Card <input type="checkbox"/> Patient Assistance Transport Scheme (PATs) <input type="checkbox"/> Other <i>(please specify)</i>

FUNCTIONAL STATUS/CARE				
How do you manage the following? <i>(please mark appropriate box)</i>				
	Completely unable	With some help	Without help	Further Information
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bathing or showering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Memory problems/confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Behavioural problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mobility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Are you at risk of falls	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Details	

FURTHER INFORMATION			
COVID Vaccination record <i>(please circle your answer)</i>			
Have you had a COVID Booster?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	Booster 1 <input type="checkbox"/> Booster 2 <input type="checkbox"/>
Medicare Number:			
Has Aged Care Assessment taken place? Yes <input type="checkbox"/> No <input type="checkbox"/>		My Age Care ID:	
Are existing services in place with other providers? Yes <input type="checkbox"/> No <input type="checkbox"/>	Provier Details: Services in place:		
NDIS Eligibility <i>(please tick)</i> Eligible <input type="checkbox"/> Ineligible <input type="checkbox"/> In progress - access request	Transition date:		Registration no:

TBCC SERVICES				
What services would you like to receive (please tick)				
Domestic Cleaning (inside) <input type="checkbox"/>	General <input type="checkbox"/>	Wet areas <input type="checkbox"/>	Bedding <input type="checkbox"/>	Other <input type="checkbox"/>
Equipment & Products <input type="checkbox"/>	Kitchen Aids <input type="checkbox"/>	Bed Sticks <input type="checkbox"/>	Safety pendant <input type="checkbox"/>	Other <input type="checkbox"/>
Home Adjustments <input type="checkbox"/>	Grab Rails <input type="checkbox"/>	Bathrooms <input type="checkbox"/>	Kitchens <input type="checkbox"/>	Other <input type="checkbox"/>
Home Maintenance <input type="checkbox"/>	Gardening <input type="checkbox"/>	Gutters <input type="checkbox"/>	Windows <input type="checkbox"/>	Other <input type="checkbox"/>
Group Activities <input type="checkbox"/>	Classes <input type="checkbox"/>	Bus Trips <input type="checkbox"/>	Luncheons <input type="checkbox"/>	Other: <input type="checkbox"/>
Individual Social Support <input type="checkbox"/>	Regular Phone chats <input type="checkbox"/>		Updates on outings and home maintenance <input type="checkbox"/>	
Meals <input type="checkbox"/>	Provided onsite <input type="checkbox"/>		Frozen meals for home <input type="checkbox"/>	
Transport <input type="checkbox"/>	Regular trips <input type="checkbox"/>		As required <input type="checkbox"/>	

CONSENT TO SHARING PERSONAL INFORMATION (Circle Your Answers)					
Do you consent to the Tailem Bend Community Centre (TBCC) sharing relevant information about you with other health or community service providers, where necessary, in accordance with the Information Sharing Guidelines (ISG), to manage or mitigate risks to your health, safety, or wellbeing, and to meet any government reporting or compliance requirements?				YES <input type="checkbox"/>	NO <input type="checkbox"/>
I consent for photos to be shared:	All Listed <input type="checkbox"/>	Social media <input type="checkbox"/>	Promotion <input type="checkbox"/>	None <input type="checkbox"/>	

To support environmental sustainability and reduce printing costs, the following documents are available online at the links below.		
I have read and understand the following documents.		
TBCC Client Information Booklet tbcc-client-information-booklet	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aged Care Statement of Rights https://www.agedcarequality.gov.au/workers/statement-rights	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aged Care Code of Conduct https://www.agedcarequality.gov.au/for-providers/code-conduct	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Aged Care Quality Standards https://www.agedcarequality.gov.au/providers/standards	Yes <input type="checkbox"/>	No <input type="checkbox"/>
TBCC Feedback & Complaint Policy Feedback and Complaints Policy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
TBCC Whistle Blower Policy Whistleblower Protection Policy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
I am unable to access digital versions and require printed copies to be mailed to me.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

TBCC Information		
How did you find out about our services? (Please tick your answers)		
Word of mouth <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/>	Internet <input type="checkbox"/> Radio/Newspaper <input type="checkbox"/> My Aged Care <input type="checkbox"/>	Referral from another provider (please specify) <input type="checkbox"/> Other (please specify)
Would you be interested in volunteering with the program? Driving <input type="checkbox"/> Companion Support <input type="checkbox"/> Vehicle cleaning <input type="checkbox"/> Administration <input type="checkbox"/> Not at this stage <input type="checkbox"/>		

I have the right to withdraw consent at any time by notifying the Tailem Bend Community Centre on 08 8572 3513 or email info@tbcc.org.au TBCC supports my choices and independence & respects my privacy.	
Full name of client Signed Date / /	
Full name of authorised person (if applicable) Client or authorised person's signature (if choosing to sign)	