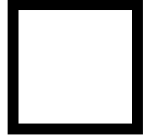

For Office Use

ACCESSABILITY
Upper Great Southern Family Support Association Inc.
APPLICATION FOR RESPITE FUNDING

1. **Full name of person with a disability:**

   ____

   Gender (please circle) **FEMALE** **MALE**

2. **Residential Address:** ____

   ______________________________________ **Post Code:** __________

3. **Date of Birth:** ____

4. **Name of Parent/s / Carer / Guardian:** ______________________________

   ____

5. **Address:** ____

   ______________________________________ **Post Code:** __________

   Postal Address (if different to residential): ______________________

   ______________________________________ **Post Code:** __________

   Contact Numbers: **Home:** ______________ **Work:** ______________

   Mobile: ______________________ **Fax:** ______________________

   Email: ____

6. What Type(s) of disability does the individual have (indicate one or more):

Intellectual	**Yes / No**
Cognitive	**Yes / No**
Neurological	**Yes / No**
Physical	**Yes / No**
Sensory	**Yes / No**
Psychiatric	**Yes / No**
Acquired Brain Injury	**Yes / No**

7. What is the principle medical diagnosis (eg.: Cerebral Palsy, Down Syndrome):

____

8. Does the Primary Carer have responsibility for other individuals with a Disability, which are resident in the same household? Yes / No

9. For the person with a disability, please indicate the assistance required across the following categories.
(Please tick ONE box per category):

Eating	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	
Washing	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	
Dressing	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	

Toileting	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	
Walking	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	
If not independently Mobile (eg. Wheel chair Or other aid), what level of assistance is needed?	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	
Communication	**Needs NO assistance**	
	Supervision only	
	Partial assistance	
	Full assistance	

10. Does this individual with a disability require supervision for his / her own safety or for the safety of others? Yes / No

11. Does the individual require assistance during the night which places demands on the carer? Yes / No

12. Does the individual with the disability have any nursing / medical requirements? Yes / No

If yes, please specify: ____

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13. How many respite hours per week would you / your family require?

Hours per week: ____

14. Is the Primary Carer also the Carer for anyone else? Yes / No

If yes, please state who else you care for (for example, a partner, other children, a Parent). You may include people you care for who do not live in the same house as you.

Relationship	Age of Person	Reason for care, and the care you provide

15. Other funding sources:
Do you currently receive funding from:

Disability Services Commission	**Yes / No**	**$______________/annum**
Access Ability	**Yes / No**	**$______________/annum**
H.A.C.C. - Home and Community Care	**Yes / No**	**$______________/annum**
Other - ____________________________	**Yes / No**	**$______________/annum**

16. In the past 12 months have you received respite support from:

Disability Services Commission	**Yes / No**
Access Ability	**Yes / No**
Silver Chain - Commonwealth Carer Respite Centre	**Yes / No**
Other - ______________________________________	**Yes / No**

17. If you have any comments in support of your application please provide them in the space below. Or alternatively, attach additional pages with this application.

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Name of the person completing this application: ______________________________

Signature: ____

Date of Application: ____

Date received by Access Ability: ____

Please note that Access Ability ensure confidentiality at all times. Information Contained in this application will only be used for the purpose as stated.