

55 CENTRAL INC.



55CENTRAL

**COMMUNITY SUPPORT
INDEPENDENT LIVING PROGRAM**

ELIGIBILITY CRITERIA

To qualify for 55 Central's Community Support Independent Living Program, applicants must meet the following criteria:

- Diagnosed with a severe and persistent mental illness
- Registered on waiting list with the Department of Housing
- Motivation to participate in their recovery
- Regular and ongoing contact with either a Psychiatrist or GP
- Capacity in managing medication regimes independently or with minimal support
- Capacity in managing basic living skills and basic self-care skills independently or with minimal support
- Be receiving an income or pension that covers accommodation expenses and in line with DOH guidelines

COMMUNITY SUPPORT INDEPENDENT LIVING PROGRAM
APPLICATION FORM

Surname:

First Name(s):

Gender:

Male ☐ Female ☐

Date of Birth:

Next of Kin:

Relationship:

Address:

Telephone:

Marital Status:

Single ☐ Married ☐ De Facto ☐

Divorced ☐ Widowed ☐ Separated ☐

Employment Status:

Full Time ☐ Part-time ☐ Casual ☐ Unemployed ☐

Income: Wages

☐ Newstart ☐ Sickness ☐

Disability

☐ Age ☐ Others ☐

CRN No.:

**Current Housing
Situation:**

**Support Needs and
Requirements:**

**Preferences or Need
For Location and/or
Type of Premises:**

Nature of Illness:

Medications:

Doctor:

Telephone:

Currently Linked?

☐

Key Worker:

Telephone:

Referral Date:

Commencement of Tenancy:

After Hours Emergency Contact:

**Please summarize what you expect of us as a service provider and how we
can support you:**

Applicant's Name:

Signature:

Date:

Staff Member's Name:

Signature: **Date:**

	YES	NO
Correction Services	<input type="checkbox"/>	<input type="checkbox"/>
Health Services including General Practitioner	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Services including psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Housing services	<input type="checkbox"/>	<input type="checkbox"/>
Homeless services and hostels	<input type="checkbox"/>	<input type="checkbox"/>

CLIENT CONSENT TO RELEASE INFORMATION

I,.....

Address:

1. I consent to information relevant to the services I receive being obtained from:
 (Name of caseworker)

2. I consent to information relevant to the services I receive from 55 Central being made available to:
 (List agencies included in consent)

.....

Client's Signature: **Date:**

Consent is effective for the period from to (dates).

☐ Verbal consent given:

Date:

Verified by:

Note: Information may be faxed to the agency's office on 93701527 or email on enquiries@55central.asn.au and should be marked to the attention of the Operations Manager.

FOR 55 CENTRAL INC. USE

Prospective Client has been Interviewed: Yes ☐ No ☐

Date of Interview:

Copy of Guidelines Given to Key Worker: Yes ☐ No ☐

PRACTICAL INFORMATION CONCERNING TENANT

Surname:

First Name:

Personal Hygiene: _____

Cleaning of Premises: _____

Budgeting: _____

Compliance to Medication: _____

Social Disposition:
(Level and Manner of Communication with Visitors, Friends etc.)

Cooking/Nutrition: _____

Shopping: _____

Miscellaneous: _____

Social support networks: