

55 CENTRAL INC.



55 CENTRAL

**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)

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.....

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: