Custodian In Home Services appreciates that everyone is unique, please help us to get to know you by answering the following:

| **Client’s Details** |
| --- |
| **Client First Name** |  |
| **Client Last Name** |  |
| **Client Date of Birth** |  |
| **Address** |  |
| **Home Phone** |  |
| **Mobile Phone** |  |
| **Email Address** |  |
| **Relationship status** |  |

| **Client’s Representative or Emergency Contact Details** |
| --- |
| **First Name** |  |
| **Last Name** |  |
| **Relationship to Client** |  |
| **Address** |  |
| **Phone Number** |  |
| **Email** |  |
| **Preferred method of contact** | ☐ **Phone**☐ **Email** ☐ **Physical Post** |

| **About Client** |
| --- |
| **Living Situation** | ☐ **Own home (alone)**☐ **Own Home (with family)** ☐ **Temporary Accommodation**☐ **Other:**  |
| **Aboriginal or Torres Strait Islander descent?** | ☐ **Yes**☐ **No** |
| **Primary Formal Diagnosis** |  |
| **Secondary Formal Diagnosis** |  |
| **Allergies***Please list as applicable* |  |
| **Medical diagnosis and medicine that may affect the support provided***Please list as applicable* |  |
| **Name and contact number for Client's Doctor***Please list as applicable* |  |
| **Any legal issues that may affect service eg. Apprehended Violence Order***Please list as applicable* |  |

| **Communication** |
| --- |
| **Type***Please provide details for “Other”* | ☐ **Verbal**☐ **Non-Verbal**☐ **Communication Aids required**☐ **Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Are you of a culturally or linguistically diverse background?***Please provide details* | ☐ **Yes**☐ **No** |
| **Language(s) Spoken***Please provide details* | ☐ **English**☐ **Other**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Is an Interpreter required?***Please provide details* | ☐ **No**☐ **Yes- Hearing Impaired**☐ **Yes- Language** |

| **My Aged Care Funding Information** |
| --- |
| **Date of Assessment Decision** |  |
| **Has Custodian In Home Services received a copy of the Assessment Decision and Care and Services Plan and Care and Services Plan developed during your assessment?** | ☐**Yes** | ☐**No** |  |  |
| **Level of Package** | ☐**Level 1** | ☐**Level 2** | ☐**Level 3** | ☐**Level 4** |
| **Primary Supplements to which you are entitled:** | ☐ **Oxygen Supplement**☐ **Enteral** **Feeding** **Supplement**☐ **Dementia** **and cognition Supplement**☐ **Veterans’ Supplement**☐ **Other** |  |  |
| **Other Supplements to which you are entitled:** | ☐ **Hardship** **Supplement**☐ **Viability** **Supplement**☐ **Other** |  |  |
| **Basic Daily Fee you must pay:** | **Per day:****Per week:****Per annum:** |  |  |
| **Income Tested Fee you must pay:** | **Per day:****Per week:****Per annum:** |  |  |
| **Custodian In Home Services confirmed appropriate funding?** | ☐**Yes** | ☐**No** |  |  |

# What Services are you interested in?

| ☐ **Assistance with care and housing**☐ **Personal care services**☐ **Nursing care services**☐ **Allied health/therapy services**☐ **Specialised support services**☐ **Social support services** | ☐ **Domestic assistance**☐ **Meals and other food services** ☐ **Home maintenance services**☐ **Home modification services**☐ **Goods, equipment and assistive technology**☐ **Transport Services** |
| --- | --- |

| **A bit about you and your goals** |
| --- |
| To help us understand you better, please fill the below: |
| 💪 | My strengths are (what I am good at)... |  |
| 👍 | I like... |  |
| 👎 | I don’t like…(please include any sensory considerations) |  |
| 🙂 | You will know when I am happy by... |  |
| 😔 | You will know when I am unhappy by... |  |
| 💬 | I prefer to communicate by... |  |
| 🙂 | What are your goals for the next 12 months? |  |
| 🙂 | How have these goals changed since your previous Support Plan (if applicable) |  |
| 👍 | How do your existing supports from us or other providers help achieve desired outcomes? Is there any opportunity to use less intrusive options, in accordance with contemporary evidence-informed practices that meet participant needs and help achieve desired outcomes. |  |

| **Consent** |
| --- |
| Please sign below to indicate your consent and agreement to the details set out in this Client Intake Form:***If you do not consent/agree, please specify:*****Signed** for and on behalf of **Custodian Aged Care Pty LtdABN 86 651 486 403** (**Custodian In Home Services**), by:……………..…………………………….. Date: ……/……/……..Signature ……………..…………………………….. Name (please print) **Signed** by the **Client**:……………..…………………………….. Date: ……/……/……..Signature ……………..…………………………….. Name (please print) **Signed** by the **Representative**:……………..…………………………….. Date: ……/……/……..Signature ………………..…………………………….. Name (please print)  |