ROSHANA
CARE GROUP

SUPPORTED INDEPENDENT LIVING (SIL)

REFERRAL FORM

SIL Referral Form

What is SIL?

Supported Independent Living (SIL) is a new model of Supported Accommodation funded by the National Disability Insurance Scheme (NDIS).

SIL is generally for people living in shared supported arrangements. Participants living on their own, requiring 24/7 care, may also be eligible for SIL when it is required as a result of high support needs.

Residents will receive support with everyday tasks like cleaning, cooking and personal care. Other areas of supports may be with:

- maintaining a household.
- building skills for shopping and cooking for healthy eating.
- accessing local community groups & activities.
- developing and maintaining connections with family and friends.
- specialised behaviour support.

Roshana Care Group works with a group of highly trained and experienced staff who can provide a safe and supportive environment in our supported homes.

Who is SIL for?

Our SIL services are suitable for people between the ages of 18 and 65 who live with a psychosocial- disability. Our residents are encouraged and supported to live as independently as possible. Each resident will have an individually tailored program of supports, depending on their needs and how they want to live their life. There are three levels of support provided under SIL:

Lower needs

This support provides supervision of living arrangements as a whole including occasional to intermittent prompting to undertake household tasks and / or self- care activities. This supervision is not usually provided 24/7.

Standard needs

This support provides 24/7 support including active assistance or supervision of most daily tasks and regular inactive overnight supports (sleepover shift).

Higher needs

This support provides intensive 24/7 support including continual, active assistance with all daily tasks, specialized behaviours support and active overnight support.

How do you access the service?

Supported Independent Living (SIL) is available for people who require access to 24/7 support and is funded through NDIS Core supports.

To be eligible, you need to fit the following criteria:

- You have an NDIS Plan with approval for Supported Independent Living OR you have funding for Investigating Housing Solutions and expect that your Plan will include Supported Independent Living funding
- You require access to 24/7 support
- You are over the age of 18

SIL Referral Form

Supporting Documents Checklist

- Primary Diagnosis of Mental Health disorder Current Client Management Plan
- Brief Risk Assessment completed by a clinician Current Mental Health Treatment/Care Plan Recent Discharge Summaries
- Occupational Therapy (OT) Assessment (if applicable)
- Details of Forensic History (if relevant)
- Any current Community Treatment Order (CTO) Medication regime
- NDIS plan (if applicable)
- Physical Health Assessment completed by a GP or attending Doctor

A referral will be deemed incomplete until we have received all of this information

SIL Referral Form

Date of Application_____

Consumer's Details

Title: Mr. / Mrs. / Miss. / Ms. / Other: _____

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name: _____

Date of Birth (dd/mm/yyyy): _____/_____/_____

Gender: □ Male □ Female □ Not stated/ inadequately described

Sexuality: _____

Pronouns: _____

Aboriginal/Torres Strait Islander: □ Yes □ No

Cultural Diversity: _____

Language Spoken: _____

Relationship Status: _____

Occupation: _____

Income Source: _____

Centrelink Details: _____

Medicare Details:_____

Private Health insurance (if any): _____

Present Accommodation Address

Home: □ Yes

_____

Retirement Unit: □ Yes _____

SIL Referral Form

Hospital: □ Yes

_____

Residential Care: □ Yes –

If yes please complete below details: Previous care (Admitted from)

_____

Phone Number: _____

Address: _____

Country: _____

Street: _____

Suburb/Town: _____State: _____ Postcode: _____

PERSON RESPONSIBLE FOR FINANCIAL DECISIONS:

□ Consumer □ Enduring Power of Attorney □ Guardian □ Next of Kin (NOK)

"Original Documents" for Enduring Power of Attorney, Guardian, NOK are required to be provided at the time of admission.

Primary Contact:

Primary Contact Relationship: _____

First Name: _____ Last Name: _____

Address: Street:

_____

Suburb: _____ State: _____ Postcode: _____

Primary Contact Telephone Numbers –

Work: _____

Home: _____ Mobile: _____

Primary Contact Email Address: _____

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Name of Family Doctor:

Will your General Practitioner Visit the facility: □ Yes □ No

General Practitioner Name Dr._____

Telephone Number: _____

Fax Number_____

Email Address:

_____

NDIS PLAN

Do you have an NDIS Plan?: □ Yes □ No

NDIS Plan Number: _____

Mental Health Diagnosis: _____

Brief Details of your diagnosis: _____

_____

_____

FORENSIC HISTORY

Do you have any outstanding charges?: □ Yes □ No

If yes, please provide details: _____

Do you have a history of Drug and Alcohol Abuse? □ Yes □ No

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Title: Mr. / Mrs. / Miss. / Ms. / Other: _____

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name: _____

Date of Birth (dd/mm/yyyy): _____/_____/_____

Gender: □ Male □ Female □ Not stated/ inadequately described

Present Accommodation Address

Home: □ Yes

_____

Retirement Unit: □ Yes _____

Hospital: □ Yes

_____

Residential Care: □ Yes –

If yes please complete below details: Previous care (Admitted from)

_____

Phone Number: _____

Address: _____

Country: _____

Street: _____

Suburb/Town: _____State: _____ Postcode: _____

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Medical Conditions

Do you have any physical/health issues or disabilities (tick all that apply & provide details below):

□ Asthma	□ Speech
□ Diabetes	□ Visual
□ Bruise or bleed easily	□ Hearing
□ Liver disease	□ Mobility impairments
□ Epilepsy	□ Respiratory Disease
□ HIV/AIDS	□ Podiatry
□ Blood Pressure	□ Dental
□ Allergies	□ Allergic to medication
□ Thyroid problems	□ Acquired head injury
□ Eating disorders	□ Substance abuse

If yes, please provide details:

Medication

Please detail any information about your regular medication:

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Do you need any support taking your medication?

□ Yes

□ No

If yes, please explain:

Have you received all your COVID-19 Vaccinations?

□ 1st □ 2nd □ 3rd □ 4th

□ Influenza Vaccination

SIL Referral Form

CONSENT

Terms and Conditions

I acknowledge the information provided is true and correct. I agree that Roshana may contact my health service providers to gather additional information to assist with my referral if needed. I consent to this referral being submitted for consideration of Roshana's Supported Independent Living services.

Signature _____ Date _____

If Guardian, please provide a copy of your Guardian Order issued by the State Administrative Tribunal.

Guardian signature _____ Date _____