WA Disability Professional Services
School Age Application/Referral Form

Disability Professional Services can include (but are not limited to):

- Occupational Therapy
- Physiotherapy
- Speech Pathology
- Psychology
- Social Work

This form is for those seeking specialist disability services for children and youth transitioning to or attending school.

For more information on the range of services available please refer to www.disability.wa.gov.au

The following service providers will accept this form:

Ability Centre (formerly known as The Centre for Cerebral Palsy) The Intake Officer PO Box 61 MT LAWLEY WA 6929 Email: therapy@abilitycentre.com.au Web: www.abilitycentre.com.au	**Rocky Bay** Manager Therapy Professional Services 13 Baling Street COCKBURN CENTRAL 6164 Fax: 6399 4112 www.rockybay.org.au
Association for the Blind PO Box 101 VICTORIA PARK WA 6979 Fax: 9361 8696 www.guidedogswa.com.au	**Senses Foundation** Manager Life Skills and Family Services PO Box 143 BURSWOOD WA 6100 Fax: 9473 5499 www.senses.asn.au
Autism Association of WA (inc) School Age Service Locked Bag 2 SUBIACO WA 6904 Fax: 9489 8999 www.autism.org.au	**Therapy Focus** PO Box 20 BENTLEY WA 6982 Fax: 9451 5480 Email: enquiries@therapyfocus.org.au Web: www.therapyfocus.org.au

***Please note, these contact details were correct at time of printing, however may be subject to change.**

INFORMATION ABOUT REFERRING

Part 1: Eligibility

To be eligible for specialist disability services a person must:

a) Have a disability as defined by the Disability Services Act 1993

The Disability Services Act (1993) defines disability as a condition that:

- Is attributable to an intellectual, cognitive, neurological, sensory or physical impairment or a combination of those impairments;
- Is permanent or likely to be permanent;
- May or may not be episodic in nature;

and results in:

- A substantially reduced capacity of the person for communication, social interaction learning or mobility; and
- A need for continuing support services.

AND

b) 1. Be legally entitled to permanently reside in Australia

AND

b) 2. Permanently reside in Western Australia.

Part 2: Service Access

To access specialist disability services, a person must meet eligibility criteria AND the provider's service access criteria.

Each provider may have different service access criteria. These can be found by contacting the provider or referring to their website.

Some providers may offer services in some areas only; any of the providers listed will be able to advise you who provides services in your area.

Fee for service is also available for individuals not eligible; please contact the provider's direct for more details.

Privacy Disclaimer:

Please note that these service providers are required to release information about service users to the Disability Services Commission and then without identifying you, to the Australian Institute of Health and Welfare (AIHW), to enable statistics about disability services and their clients to be compiled.

The information will be kept confidential. This information is used for statistical purposes only and will not be used to affect your entitlements or your access to services. As a user National Disability Agreement (NDA)-funded services you have the right to access your own files and to update or correct information included in the Annual Client and Service Data Collection (ACDC) collection.

Section 1 | Applicants Details

Child's Contact Details

Preferred Name: _____

Given Name: _____

Surname: _____

Male / Female (Please Circle) Date of Birth: _____

Country of Birth: _____

Australian Permanent Residency Status:

- ☐ Australian Citizen
- ☐ Australian Permanent Resident
- ☐ New Zealand Citizen
- ☐ Other (Please Specify) _____

Address:

Home Address: _____

Suburb: _____ Post Code: _____

What is the **Main** language spoken language? _____

Do you require Interpreter services?

- ☐ No
- ☐ Yes - for non-spoken communication
- ☐ Yes - for spoken language other than English

What is your most effective form of communication?

- ☐ Little or no effective communication
- ☐ Other effective non-spoken communication
- ☐ Sign Language
- ☐ Spoken Language

Are you of ...?

- ☐ Aboriginal but not Torres Strait Islander Origin
- ☐ Both Aboriginal and Torres Strait Islander Origin
- ☐ Torres Strait Islander but not Aboriginal Origin
- ☐ Neither Aboriginal origin nor Torres Strait Islander Origin

Who do you live with:

- ☐ Live with family
- ☐ Live with others (please specify) _____

Residential Setting:

- ☐ Private Residence
- ☐ Residence within an Aboriginal/Torres Strait Islander community
- ☐ Short term crisis accommodation or transitional accommodation
- ☐ Other (please specify) _____

Section 2 | Compensation

Are you applying for compensation for this child? **Yes/No**

Are you currently receiving compensation for this child? **Yes/No**

If yes to either of the above, please provide details:

Insurance Agency: (e.g. ICWA) _____

Claim Number: _____

Claim Manager: _____ Contact no: _____

Postal or email address: _____

_____

Solicitor's Agency: _____

Solicitor's Name: _____ Contact no: _____

Postal or email address: _____

_____

Section 3 |Parent / Carer / Legal Guardian Details

Please advise if there are any specific custody or access provisions you wish us to be aware of:

_____

_____

Primary Contact (Parent/Carer/Legal Guardian)

Given Name: _____

Preferred Name: _____ Surname: _____

Relationship to Service User: _____

Home Address: _____

_____ Post Code: _____

Phone Number:
(Home/Work/Mobile) _____

Email Address: _____

Spoken Language: _____ Interpreter Required? **Yes/No**

Alternative Contact (optional)

Given Name: _____

Preferred Name: _____ Surname: _____

Relationship to Service User: _____

Home Address: _____

_____ Post Code: _____

Phone Number:
(Home/Work/Mobile) _____

Email Address: _____

Spoken Language: _____ Interpreter Required? **Yes/No**

Section 4 | Disability

What is the child's primary/ main disability? **– Please indicate with a tick (√)**
What additional disabilities does your child have? **– Please indicate with a cross (x)**

- [ ] Acquired Brain Injury
- [ ] Specific Learning - other than Intellectual _____
- [ ] Attention Deficit (hyperactivity) Disorder
- [ ] Autism Spectrum Disorder / Pervasive Developmental Delay
- [ ] Developmental Delay*
- [ ] Intellectual (includes Down Syndrome)
- [ ] Multiple Sclerosis
- [ ] Other neurological (please specify)_____
- [ ] Cerebral Palsy
- [ ] Motor Neurone Disease
- [ ] Muscular Dystrophy
- [ ] Para/quadri(tetra)/hemiplegia
- [ ] Spina Bifida
- [ ] Other physical disability (please specify)_____
- [ ] Psychiatric Disability _____
- [ ] Deaf blind - dual sensory
- [ ] Vision _____
- [ ] Hearing _____
- [ ] Speech Impairment _____
- [ ] Other (please specify) _____

*Developmental Delay is a valid diagnosis for children in the age group 0 - 6 years only.

Any supporting documentation you wish to provide may assist us to make a faster assessment of this application.

Section 5 | Health and Behaviour

Has the child had, or going to have, surgery or specialist medical attention:

- [ ] No
- [ ] Yes (Please Specify) _____

For the child, are any of the following issues present?

- [ ] Aspiration (gagging, choking or recurrent chest infections)
- [ ] Difficulty swallowing during mealtimes
- [ ] Tracheostomy
- [ ] Suctioning and/or oxygen therapy
- [ ] Urinary catheter or stoma
- [ ] Pressure sores
- [ ] Significant pain or discomfort
- [ ] Self-injurious behaviour or behaviour that puts other people at risk
- [ ] Excessive weight gain or loss
- [ ] Any other health concerns (Please specify)_____

Section 6 | Help and Supervision

Please indicate the level of help or supervision required in each life area. (rows a-g)

Tick only one level of help or supervision (columns 1-4)

Any supporting documentation you wish to provide may assist us to make a faster assessment of this application.

	1. Unable to do or always needs help/ supervision	2. Sometimes needs help/ supervision	3. Does not need help but uses aids/equipment	4. Does not need help and does not use aids/ equipment
a)Self Care: • Washing • Dressing • Eating • Toileting	☐	☐	☐	☐
	Please describe help/equipment needed:			
b)Mobility • Moving around home • Getting in/out of a bed or a chair • Transport - private and/or public	☐	☐	☐	☐
	Please describe help/equipment needed:			
c)Communication: • Making self-understood • Understanding others	☐	☐	☐	☐
	Please describe help/equipment needed:			
d) Interpersonal Relationships: • Making and keeping friends • Behaving in acceptable ways • Coping with feelings	☐	☐	☐	☐
	Please describe help/equipment needed:			

Section 6 | Help and Supervision (continued)

	1. Unable to do or always needs help/ supervision	2. Sometimes needs help/ supervision	3. Does not need help but uses aids/equipment	4. Does not need help and does not use aids/ equipment
e) Learning: • Understanding new ideas • Remembering • Problem solving • Decision making • Paying attention • Undertaking single or multiple tasks • Carrying out daily routine	☐	☐	☐	☐
	Please describe help/equipment needed:			
f) Education: • Actions, behaviours and tasks an individual performs in an education setting, eg. school, college.	☐	☐	☐	☐
	Please describe help/equipment needed:			
g) Community Participation: • Recreation and leisure • Religion and spirituality • Human rights • Political life and citizenship • Economic life, such as handling money	☐	☐	☐	☐
	Please describe help/equipment needed:			

Section 7 | Other Supporting Agencies

If you have consented to us contacting other parties, please feel free to provide their contact details below:

Existing Service Provider

Name: _____

Contact: _____

Local Area Coordinator / My Way Coordinator

Name: _____

Contact: _____

School

School Name: _____

School Suburb: _____

Class Level/Year: _____

Class Teacher's Name: _____

Contact: _____

General Practitioner

Name: _____

Practice: _____

Contact: _____

Other

Name: _____

Contact: _____

Organisation _____

Section 8 | Consent for Eligibility Screening

Collection:
I/we understand that the personal information provided on this form is collected for the purpose of determining eligibility for my child to receive school age services.

Child's Name _____ DOB _____

Parent / Legal Guardian's Name _____

Use of Information:
I/We give _____ (Service Provider/s selected) consent to access the following reports and information regarding _____ (Child's Name) to assess if he/she is eligible to receive services:

- ☐ Medical Reports _____
- ☐ Therapy Reports _____
- ☐ Educational Reports _____
- ☐ Psychological Reports _____
- ☐ Other _____

Third party disclosure:
I/We give _____ (Service Provider/s selected) consent to contact the following person/s or agencies regarding _____ (Child's Name) to seek supporting information for this application:

- ☐ General Practitioner _____
- ☐ Medical Specialist _____
- ☐ Other Therapy Provider _____
- ☐ Education Provider _____
- ☐ Care / Respite Provider _____
- ☐ Disability Service Commission _____
- ☐ Other/s _____

Secondary Purposes:
From time-to-time, your chosen Service Provider/s may like to use your contact details to include you in mass communications. Please tick the box if you would like to receive any of the following:

- ☐ Newsletters
- ☐ Communication about groups
- ☐ Communication about other Service Providers (including waitlist updates)
- ☐ Communication about other community services available
- ☐ Other _____

Storage, Access and Correction: Service Providers obligations under the *Privacy Act 1988*
All Disability Professional Service Providers are bound by the *Privacy Act 1988*. As such, all providers undertake to adhere to the National Privacy Principles which appear in Schedule 3 of the Privacy Act; which regulate how we may collect, use, disclose and store personal information and how individuals may access and correct personal information held about them. For further information please refer to www.privacy.gov.au or www.comlaw.gov.au

Signed: _____

Name: _____

Relationship to Child: _____ **Date:** _____

Section 9 | Checklist

Person completing this form *(If not parent/legal guardian)*

Name: _____

Contact Phone Number: _____

Postal Address: _____ Post Code: _____

Email Address: _____

Relationship to Child: _____

Checklist:

The following sections have been completed:

- ☐ Child's Contact Details
- ☐ Compensation Details (if applicable)
- ☐ Parent / Carer / Legal Guardian Contact Details
- ☐ Disability
- ☐ Health and Behaviour section
- ☐ Help and Supervision section
- ☐ Consent for Eligibility
- ☐ Other Supporting Agencies Contact Details
- ☐ Person Completing this Form
- ☐ Checklist and Supporting Documentation

Required supporting documentation attached:

- ☐ Evidence of Australian Permanent Residency (such as Australian Birth Certificate, Passport or Visa)
- ☐ Evidence of permanently residing in Western Australia (such as a phone bill, electricity bill e.t.c)
- ☐ Evidence of Diagnosis (such as report from General Practitioner or Specialist stating diagnosis)
- ☐ Evidence of Health and Behaviour (optional)
- ☐ Evidence of Help and Supervision (optional)

Please return this form to:

The Intake Officer
PO Box 61
MT LAWLEY WA 6929

OR

The Ability Centre's email: therapy@abilitycentre.com.au