

Supported Accommodation Application Form FM-OPS-021



If you have any questions about this form, require assistance to complete or would like additional information about Windgap Services, please contact us on (02) 83373600 or email info@windgap.org.au

Section 1 – Participant Details

First Name:								
Surname:								
Preferred Name:								
Date of Birth:								
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unspecified							
Email:								
Do you currently receive Centrelink?							<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you receive Rental Assistance							<input type="checkbox"/> Yes <input type="checkbox"/> No	
NDIS Number:								
Mobile Phone:				Home Phone:				
Home Address:					State:		Postcode:	
Postal Address:	<input type="checkbox"/> As above <input type="checkbox"/> Other				State:		Postcode:	
Please include a Picture of the Applicant in this space not older than 6 Months								
Preferred Contact Details for Emergency Contact								
Name:				Phone Number:				
Relationship:				Email:				

Section 2 – Details of Disability

Primary Disability:			
Other Disabilities, Please List	•		
	•		
	•		

Section 3 - Preferences

Who would I like to live with?	<input type="checkbox"/> Male Residents <input type="checkbox"/> Female Residents <input type="checkbox"/> Both	Who I would like supporting me?	<input type="checkbox"/> Male Staff <input type="checkbox"/> Female Staff <input type="checkbox"/> No preference
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What are 5 things that are important to you when looking for supported accommodation?

- 1.
- 2.
- 3.
- 4.
- 5.

What are 5 activities that you like to do?

- 1.
- 2.
- 3.



4. 5.
What are 5 things that you are good at?
1. 2. 3. 4. 5.
What are 5 things that you sometimes find hard?
1. 2. 3. 4. 5.

Section 3 – Support Needs							
Do you require any Mobility Aids? Please specify below;	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you use any incontinence aids?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
		Specialised Vehicle requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you require staff to provide invasive procedures? If yes, you will be contacted for clarification.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you require Windgap staff to assist in the administration of medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any of the following conditions:							
Diabetes	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Other, please indicate below	
Are there specific supports required to manage these, please list.							
*I am able to attach and send through the following reports:							
<input type="checkbox"/> Anaphylaxis Management Plan	<input type="checkbox"/> Asthma Management Plan	<input type="checkbox"/> Epilepsy Management Plan					
<input type="checkbox"/> Behaviour Support Plan	<input type="checkbox"/> Diabetes Management Plan	<input type="checkbox"/> Mealtime Management Plan					
<input type="checkbox"/> OT Functional Assessment	<input type="checkbox"/> Speech Therapy Report	<input type="checkbox"/> Psychologist Report					
<input type="checkbox"/> Other Medical Reports, Please list.							

Section 4 – Behaviour Support and Restrictive Practices			
Do you have a Behaviour Support Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are there any Restrictive Practices in the plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behaviour Support Plan Type:	<input type="checkbox"/> Comprehensive <input type="checkbox"/> Interim		



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If yes to Restrictive Practices what is the type?	<input type="checkbox"/> Chemical	<input type="checkbox"/> Environmental	<input type="checkbox"/> Mechanical
	<input type="checkbox"/> Physical	<input type="checkbox"/> Seclusion	
If yes to Restrictive Practices, are you able to provide a copy of a current NCAT Authority Form for the use of restrictive practices.			<input type="checkbox"/> Yes <input type="checkbox"/> No
If No, please list barriers to Restrictive Practice Authority.			

Section 5 – NDIS Funding	
Do you have a Current NDIS Plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your Current Plan have Supported Independent Living (SIL) funding approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your Current Plan have Specialist Disability Accommodation (SDA) funding approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been with another Supported Independent Living (SIL) Provider in the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of previous Supported Independent Living (SIL) provider?	
What was your main reason for leaving your previous Supported Independent Living (SIL) Provider?	

Section 6 - Acknowledgements	
Please note that if you do not consent to the collection of your personal information, Windgap may not be able to assist you. More information about collection, use, disclosure and storage of your personal information can be provided by contacting Windgap on (02) 8337 3600 or email info@windgap.org.au .	
<p>Do you give permission for the following:</p> <p>1. Information – Windgap to collect information from third parties as indicated in section 2, 3, 4 and 5 of this form, please indicate.</p> <p><input type="checkbox"/> Yes, I consent. <input type="checkbox"/> No, I do not consent.</p> <p><i>Please note that consent for information in this form is separate from consent for information in Windgap's Intake Consent Form that will be completed before start of service delivery.</i></p>	
Participants Full Name:	Signature: _____ Date: _____
Representative Full Name: **	Signature: _____ Date: _____

****Windgap may require evidence of your authority to sign on the behalf of the participant.**



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Date of review: 15/02/2024
 Reviewer/s: GMDS, SNR Residential Supervisor, COM&SAF MGR