

# PLACEMENT APPLICATION FORM

## GENERAL INFORMATION

This Application Form is to be used to apply for the following services which are provided by Non – Government Organisations for Mental Health Services:

- Residential Rehabilitation and Supported Accommodation Program
- Packages of Care
- Recovery Program

(Please see “General Information and Overview of Service Options” for more detail about these services).

There are three sections, A, B & C.

Section A and Section B must be completed by applicants wishing to apply for an Aspire Recovery Program.

Sections A, B & C must be completed by applicants wishing to apply for Richmond Fellowship Supported Accommodation Program and Recovery Program, Family Based Care and Anglicare.

All applicants should also complete the Checklist on Page 8.

If you require additional information to assist in this process please ring the Mental Health Service Area Management Unit in your region on:

**North West: 6434 4070**

**North: 6336 2196**

**South: 6233 6011**

Once completed, all the documentation should be enclosed in an envelope marked **CONFIDENTIAL** and sent to the relevant Area Management Unit (address on Page 8).

This will allow applications to be assessed by the Maximising Recovery Panel and a determination made whether or not additional services will be provided. The MRP meets monthly and all applicants will be informed in writing of the outcomes of this process.

Mental Health Services (MHS), as part of the Department of Health and Human Services (DHHS), collects personal information from you for the purpose of your application to the Maximising Recovery Panel (MRP) and this information will be used by the MRP to determine the appropriate service option. If MHS does not receive all the information required, the MRP may not be able to adequately assess your application.

The service options are provided by Non Government Organisations (NGOs) and MHS will ask for your consent to disclose some or all the information MHS collects to the recommended service option provider (NGO).

Throughout this process, your personal information will be managed by MHS and NGOs in accordance with the *Personal Information Protection Act 2004* and you may access your information on request. For further information about DHHS management of your personal information, you can review the personal information protection policy at [www.dhhs.tas.gov.au/aboutus/pip.php](http://www.dhhs.tas.gov.au/aboutus/pip.php) or MHS can provide you with a copy of the policy.



# A. CONSENT

I, \_\_\_\_\_ (Your full name)

Please print clearly

give my consent for an Application to be made to the Maximising Recovery Panel for a Non Government Organisation Service Option(s).

I have discussed this Application with my Case Manager/Designated Clinician

\_\_\_\_\_ (Name of Case Manager/Designated Clinician)

Please print clearly

and understand and give consent where applicable, that:

1. Mental Health Services will collect, review, hold and where necessary provide my personal information (including mental health history) to the NGO supplying the service requested in this application. The collection, use and disclosure of this information is governed by the Personal Information Protection Act 2002 (PIP Act).
2. This application will be forwarded to the Maximising Recovery Panel with details of my personal information.
3. The Maximising Recovery Panel will consider my application and will advise me of one of the following outcomes:
  - Recommend to commence orientation with an NGO service option provider;
  - Recommend to be placed on a waiting list;
  - Non acceptance but with recommendations to Case Manager/Designated Clinician.
4. If the Maximising Recovery Panel recommends me for a service option, I give consent for a copy of this Application, to be given to the NGO providing me with the service option.

Applicant \_\_\_\_\_ / /  
*Signature*

Witness \_\_\_\_\_ / /  
*Signature*



<b>MRP IDENTIFIER NO.</b>	
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## B. APPLICATION

### APPLICANT INFORMATION

Please print clearly:

**First Name:**

**Middle Name:**

**Last Name:**

UR Number :	Language Spoken :	Date of Birth:	Age:	Gender	
				<input type="checkbox"/> M	<input type="checkbox"/> F

**Street address:**

**Mobile no.:**

**Contact Phone no.:**

**Legal Status e.g. IO,CCO,CTO**

**Guardianship Orders: (Please state if any)**

**Person responsible: (if other than self)**

**Mental Health : Diagnosis**

**Responsible Clinician:**

**Community Mental Health Service:**

**Application made by (Referrer):**

**Relationship to Applicant:**

**Date of Application:**

<b>As Referrer, do you wish to attend the MRP meeting where this application will be discussed? – Maximum of 10 minutes</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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<b>Office Use only – if YES – Advised Referrer of Date/Time/Venue or relevant MRP Meeting -</b>	<input type="checkbox"/> Yes
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<b>MRP IDENTIFIER NO.</b>	
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**B. APPLICATION CONTINUED**

*Case Manager / Referrer expectations of the Application:*


IF YOU REQUIRE MORE SPACE, PLEASE ATTACH ANOTHER SEPARATE SHEET TO THIS APPLICATION.

**If the applicant is a client of MHS please attach a current copy of a Mental Health Risk Assessment if available**

All referrers must also complete the following scale

1	2	3	4
Low level of risk		Significant difficulties	

**Please rate the following from the Rating Scale above: If an item is rated 3-4 provide further details on the following page.**

**Risk / Issues:**

Medication adherence issues	
Alcohol and drug issues	
High relapse frequency	
Suicide Risk	
Harm to others	
Self Harm	
Harm from Others	
Care of self	
Daily living skills	
Level of support	
Housing Issues	
Self esteem/confidence	
Vocational Issues	
<b><u>Parenting Issues</u></b>	

<b>MRP IDENTIFIER NO.</b>	
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## C. ADDITIONAL INFORMATION

### Current medication, dosage and frequency


### Current therapy / programs


IF YOU REQUIRE MORE SPACE, PLEASE ATTACH ANOTHER SEPARATE SHEET TO THIS APPLICATION.

### Inpatient Admissions (Please include first admission and last four only)

Date	Length of admission (if known)	Discharge diagnosis (if known)



<b>MRP IDENTIFIER No.</b>	
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## Checklist for Client & Referrer:

**Please tick when completed:**

Client has signed the Consent Form (Page 2)	<input type="checkbox"/>
Witness has signed the Consent Form (Page 2)	<input type="checkbox"/>
Client has completed personal details (Page 3)	<input type="checkbox"/>
Copy of MHS Risk Assessment (attached if available)	<input type="checkbox"/>
Referrer has signed Consent & Application Form (see below)	<input type="checkbox"/>

**Supporting Documentation Attached:**

Current Management Plan/Individual Service Plan (ISP) (Compulsory)	<input type="checkbox"/>
Relapse Plan	<input type="checkbox"/>
Recovery Plan	<input type="checkbox"/>

**Referrer's Signature:**

	/ /
<i>Signature</i>	<i>Date</i>

**Please enclose in an envelope marked CONFIDENTIAL and send to:**

**For North West:**

**Maximising Recovery Panel**

North West Area Management Unit  
Mental Health Services  
112 Wilson Street, Burnie

P.O. Box 258, Burnie 7320  
Ph. 6434 4070 Fax 6434 4085

**For North**

**Maximising Recovery Panel**

Northern Area Management Unit  
2nd Floor, 63-65 Cameron Street  
Launceston, 7250

PO Box 708, Launceston 7250  
Ph: 6336 2196

**For South:**

**Maximising Recovery Panel**

Southern Area Management Unit  
10 Elphinstone Road  
North Hobart, 7002

PO Box 443 Nth Hobart 7002  
Ph: 6233 6011

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