

Stride Residential Services
| NDIS SIL

**Expression of
Interest**

Participant Profile

Expression of Interest for Individuals Seeking Accommodation Service

This profile is required for an individual to be considered for a supported accommodation vacancy. Lodgment of this form does not guarantee a placement.

Applicants will be assessed by Stride Residential Services as per the Eligibility and Priority criteria for Psychosocial Support. Stride Residential Services will treat all information as confidential.

Please note that this profile should clearly reflect an individual's consistent support requirements.

PLEASE ENSURE THAT THIS PROFILE IS CORRECTLY ENDORSED BEFORE SUBMITTING TO STRIDE RESIDENTIAL SERVICES.

Applicants Name	
Date Profile Completed	
Profile Completed By	
Contact Name	
Contact Phone Number	
Email Address	
Name and Address of Organisation	
Profile Endorsed By	
Position Title	
Contact Phone Number	

PLEASE COMPLETE ALL RELEVANT SECTIONS AND RETURN TO:

Stride Residential Services SIL@Stride.com.au

Consent of Applicant or Applicant's Guardian or Person Responsible

I,

OR, Insert Name

The Insert Name Person
Responsible on Behalf Of

OR,

The Guardian on Behalf Of Insert Name

Agree that my signature / mark below represents my understanding that:

1. The information provided in the Participant Profile may be recorded on the Register of Expressions of Interest for supported Accommodation.
2. The Register of Expressions of Interest is not a waiting list. Supported accommodation placement service is provided on a needs basis each time a vacancy occurs;
3. If there are any significant changes to information provided on this form, an updated Client Profile detailing the changes need to be forwarded to the Service Manager of Stride Residential Services SIL@Stride.com.au

SIGNED: _____

DATE: _____

Name of Participant:					
Current Address:					
Date of Birth:					
Gender:	Female <input type="checkbox"/>	Male <input type="checkbox"/>	Transgender <input type="checkbox"/>	Intersex <input type="checkbox"/>	Other <input type="checkbox"/>
Primary Diagnosis:					

General Information			
Country of Birth			
Australian Citizen	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Preferred Language Spoken			
Interpreter Required	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Aboriginal or Torres Strait Islander (ATSI)	<input type="checkbox"/> Aboriginal (not Torres Strait Islander) <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Declined to Respond		
Family Identify as CALD	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Interpreter Required	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Cultural/Religious Preference			
Age of Primary Care (if applicable)			
Medical Diagnosis			
Disability Type			
Intellectual <input type="checkbox"/>			
Physical <input type="checkbox"/>			
Sensory <input type="checkbox"/>			
Psychiatric <input type="checkbox"/>			
ABI <input type="checkbox"/>			
Other (please specify) <input type="checkbox"/>			
Medical Contact/Information			
Doctors Name		Contact Details	
Doctors Address			
Guardian Information			
Appointed Guardian/s			
Guardian Name		Phone	
Address			
Are finances managed by Trustee & Guardian?			
		Yes <input type="checkbox"/>	No <input type="checkbox"/>
T & G Manager		Contact Details	

NDIS				
NDIS Number		When does the plan expire?		
NDIS Planner Name		Planner Contact details		
Local Area Coordinator		LAC Contact details		
NDIS Plan Management	Self-Managed <input type="checkbox"/>	NDIA Managed <input type="checkbox"/>	Plan Management <input type="checkbox"/>	
Plan Management Provider		Contact Details	Ph:	
			Email:	
NDIS Plan (if additional room is required please use the notes page)				
Support Area				
Service Provider	Description of Support	Days	Times	Frequency
Support Area				
Service Provider	Description of Support	Days	Times	Frequency
Support Area				
Service Provider	Description of Support	Days	Times	Frequency
Does the applicant require house modifications?				
Other Funding Details (if applicable)				
Funding Type	<input type="checkbox"/> NDIS	<input type="checkbox"/> Fee for Service	<input type="checkbox"/> Other (specify)	
Supported Independent Living (SIL) Funding status	<input type="checkbox"/> EHOP completed	<input type="checkbox"/> SIL funding in current plan	<input type="checkbox"/> If no SIL has change in circumstances been submitted	
Amount Received	\$			
Start Date		End Date		

Relevant Contacts for Participant (Parent, Carer, Guardian, Advocate, Person Responsible, Support Coordinator)			
Name	Relationship to Participant	Address or Email	Contact Phone Number

Reason for Application	
Why is this person applying for accommodation at this time?	
What is the most appropriate model of accommodation for this participant?	<input type="checkbox"/> 24-hour awake shift group home <input type="checkbox"/> Sleep over support group home <input type="checkbox"/> Drop-In support (how many hours): <input type="checkbox"/> Other (please specific):
Is the participant prepared to be scoped for vacancies that arise within Stride?	
Describe the current family or support network and frequency of contact.	

Current Placement	
What is the nature of the current accommodation placement? Please Select	<input type="checkbox"/> Crisis, emergency or transition <input type="checkbox"/> Adult Respite Unit <input type="checkbox"/> An un-funded accommodation situation with other clients <input type="checkbox"/> Respite bed in Large Residential Centre <input type="checkbox"/> Family Home <input type="checkbox"/> Institutional setting <input type="checkbox"/> Public Shelter <input type="checkbox"/> Indigenous community/settlement <input type="checkbox"/> Group Home <input type="checkbox"/> Boarding House <input type="checkbox"/> Hostel <input type="checkbox"/> Other:
Describe Current Accommodation Placement. Please include length of time in this accommodation placement.	

Current Services			
Is the person a participant of a Community Service?	<input type="checkbox"/> Yes (If YES, do they have an allocated Case Worker from Community Services?) <input type="checkbox"/> No		
Name			
Designation			
Office			
Contact Details			
What services does the participant currently receive? Please list all			
Service Provider	Contact Person and number	Service Type	Hours support provided per week

Does the participant attend day program or work placement				
Service Provider	Location	Type of Service	Attendance	Transport

<p>Which level of support (High, Standard, or Low) do you believe this individual would require in Support Independent Living</p>	
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Assessment

Have any previous assessments been completed to indicate the person's support needs and/or future placement needs? (e.g. WHODAS, Client Needs Assessment, therapy assessments, behaviour intervention assessments)

If so, state date and nature and attach copy/s

ASSESSMENT	DATE	BY WHOM?	RESULTS

Support Needs

<p>Self-Care Skills – How Independent is the participant in her/his self-care skills?</p>	<p><input type="checkbox"/> No assistance required with personal care/bathing/dressing</p> <p><input type="checkbox"/> Needs prompting to complete personal care/bathing/dressing tasks</p> <p><input type="checkbox"/> Needs prompting with all aspects of personal care/bathing/dressing tasks</p> <p><input type="checkbox"/> Needs part of personal care/bathing/dressing tasks completed by carer</p> <p><input type="checkbox"/> All aspects of personal care/bathing/dressing tasks completed by carer</p>
<p>Does the person have any special needs in any of these areas? Please comment</p>	

Assessment	
<p>Movement and Mobility Skills – How independent is the participant in his/her movement and mobility skills?</p>	<p><input type="checkbox"/> No assistance required with mobility</p> <p><input type="checkbox"/> Needs prompting to be mobile</p> <p><input type="checkbox"/> Needs prompting and some assistance to be mobile</p> <p><input type="checkbox"/> Needs assistance to walk or use wheelchair</p> <p><input type="checkbox"/> Needs carer to push wheelchair at all times</p>
<p>Does the person have any special needs in any of these areas? Please comment</p>	
<p>Self-Protective Skills - The capacity of the participant to use self-protective behaviours at home and in the community (stranger danger, can call for assistance in emergency)</p>	<p><input type="checkbox"/> No assistance required with personal safety</p> <p><input type="checkbox"/> Needs prompting to maintain personal safety</p> <p><input type="checkbox"/> Needs prompting with all aspects of personal safety</p> <p><input type="checkbox"/> Needs supervision with all aspects of personal safety</p> <p><input type="checkbox"/> Dependent on carer for all aspects of personal safety</p>
<p>What is the person's capacity to be left unsupervised? Please comment</p>	
<p>Communication Skills – In what way and how well does the participant communicate?</p>	<p><input type="checkbox"/> Able to communicate with others verbally</p> <p><input type="checkbox"/> Able to make needs known to others</p> <p><input type="checkbox"/> Able to make some needs known to others</p> <p><input type="checkbox"/> Sign-language or augmentative communication aids to communicate</p> <p><input type="checkbox"/> Unable to communicate or make needs known to others</p>
<p>Does the person have any special needs in any of these areas? Please comment</p>	
<p>Sleeping Patterns/Physical Night Support – What are the individual's sleeping</p>	<p><input type="checkbox"/> No physical assistance required at night</p> <p><input type="checkbox"/> Requires occasional prompting to go to bed or complete own physical support</p> <p><input type="checkbox"/> Requires occasional assistance at night</p> <p><input type="checkbox"/> Requires full care with physical support at night</p>

Assessment	
patterns/support requirements at night?	Physical support relates to frequent turning and pressure area care, changing catheter bags, administering medication and managing incontinence.
Does the person have any special needs in any of these areas? Please comment	

Please provide details on the participant's ability to engage in the areas of			
Activity	Dependent	Independent	With verbal prompting, physical assistance
Travel			
Money skills			
Household tasks			

What is the best Staff/Participant support ratio? (i.e 1:1 support in the community, 1:3 overnight)		
Community Access	During the Day	Overnight

<p>Please detail any historical and current risks and/or behaviours for this person. Current risk assessment is required to be attached and a BIS plan if in use.</p> <p><input type="checkbox"/> (Attach documents)</p>	
<p>Does the person have any significant health/ medical support needs? Please describe any regular medical service / monitoring required. If so,</p>	

Assessment	
a management plan is required please attach.	
Provide details on any implemented restrictive practices i.e locked cupboards or restrictive practices around sharps.	
What are the person's likes, dislikes and hobbies e.g. food, clothes, outings, movies, TV, games, music.	

Final Checklist:

For your application to be processed, please ensure you have attached the following with this application:

- Behaviour Intervention Plan
- Risk Assessment
- NDIS Number and Plan
- Restrictive Practice Documentation