**Carer Programs**

**Top Up Application Form**

(Case Managed Package)

To be attached to S2S referral to service **LCHS/Gippsland Wide/Top Ups & Mini Registrations for Events/Service Enhancement Applications**.

Only acceptedas a ***Word document*** (not PDF) **Carer Part B not required**

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| **Case Manager/Applicant and Package Details** |
| Name of Person completing this referral |  |
| Role of Person completing this referral |  |
| Organisation |  |
| Telephone Number |  |
| Email Address |  |
| Current Case Managed Package Type: *(HCP Level 1,2,3,4/NDIS/Carer Gateway)* |  |
| Is the package fully expended or request not able to be funded by the package? | Yes [ ]  No [ ]   |
| Is financial hardship cited in support of your funding application? | Yes [ ]  No [ ]  If ***yes***, please attach a summary of financial hardship experienced over and above what you would expect for the income level.  |
| **Primary Carer Details** |
| Carer Name |  | DOB: |  |
| Address |  |
| Phone number |  |
| Country of birth |  |
| Language spoken at home |  | Interpreter required  | **Yes/No** |
| Indigenous Status: *(Aboriginal/Torres Strait Islander)* |  |
| Relationship to care recipient |  |
| Accommodation type*: (eg: Private owned, private rental, public rental, supported…)* |  |
| Hours spent caring per week: *(0- 20, 20-39, 40 + hours)* |  |
| Date caring role commenced |  |
| Income Type of Carer: *(Employed/Pension Type)* |  | DVA Card type |  |
| Employement Status: *(Casual/PT/FT/Casual)* |  |
| Do you have consent to release carer’s data? | Yes [ ]  No [ ]   |
| Briefly describe the carers emotional, physical health and wellbeing? |  |
| **Care Recipient Details** |
| Care Recipient Name |  | DOB: |  |
| Address |  |
| Phone number |  |
| Country of birth |  |
| Language spoken at home |  | Interpreter Required: | **Yes/No** |
| Indigenous status: *(Aboriginal/Torres Strait Islander)* |  |
| Accommodation Type: *(eg Private owned, private rental, public rental, supported…)* |  |
| Income Type of Care Recipient: *(Pension Type)* |  | DVA Card type |  |
| Diagnosis |  |
| Living Arrangements: *(Alone/Family/Other)* |  | Co-resident carer  | **Yes/No** |
| Do you have consent to release care recipient’s data? | Yes [ ]  No [ ]   |
| **Funding Request Details*****(All relevant sections must be completed for this application to be considered)*** |
| **Residential Respite:** *(Cap on funding: A maximum 50% of the respite stay booked & up to 4 weeks in a f/year unless proof of financial hardship is provided)* |
| Name of the facility booked: |  |
| Contact email address for facility: |  |
| Is the Residential Facility accredited? *(Must be accredited for funding)* Search myagedcare, then click, confirm accreditation status <http://www.myagedcare.gov.au/#!/service-finder?tab=aged-care-homes> | Yes [ ]  No [ ]   |
| Admission Date: |  |
| Discharge Date: |  |
| Total number of nights: |  |
| Total cost of respite: | **$**  |
| Contribution Carer/Recipient/Other **will be** making towards the respite: | **$** |
| Contribution you are seeking from Carer Programs towards the respite: | **$** |
| **In-Home Respite:** *(Package must be fully expended.* ***Respite must be booked*** *and specific dates and times stated on application. If multiple shifts have been booked with varying times and duration, please attach schedule of shifts to application with estimated cost - only short term requests will be considered)* |
| Name of service provider: |  |
| Commencement of respite date: |  |
| Last Date of respite: |  |
| Start time of respite shifts: (am/pm) |  |
| End time of respite shifts: (am/pm) |  |
| Total number of respite shifts booked: |  |
| Total cost of respite: | **$**  |
| Contribution Carer/Recipient/Other **will be** making towards the respite: | **$** |
| Contribution you are seeking from Carer Programs towards the respite: | **$** |

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| **One off Equipment Purchase:** *(letter of recommendation from a health professional eg OT as well as quote from service provider will need to be submitted with application)* |
| Equipment to be purchased: |  |
| Reason for purchase: *(How does this assist the carer/care recipient?)* |  |
| Supplier name: |  |
| Supplier contact details: |  |
| Recommendation from health professional attached: *(is required)* | Yes [ ]  No [ ]   |
| Quote from supplier attached: *(is required)* | Yes [ ]  No [ ]   |
| Total cost of purchase: | **$**  |
| Contribution you are seeking from Carer Programs towards the purchase: | **$** |
| **Additional Information in Support of Your Application:** *(please include any other information which you feel may support a favourable outcome for your application).* |
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| **Feedback to Case Manager/Applicant *(Office Use Only)*** |
| **Top Up Request** Approved in full: [ ]  Part Approved only: [ ]  Not approved: [ ]   |
| **Approved by:** Clinical Lead/Manager: Signature:  |
| **Confirmation of amount and dates approved** |  |
| **Please ensure we are notified of any changes to approved respite.** |
| TCM Carer ID:        | CP Funding Source:        |

**Short Term Top Up of Case Managed Packages**

**Guidelines and Information**

***How we can help:***

Carer Programs supports carers by providing respite services. Our main priorities are Gippsland carers who receive minimal support. Where a person is in receipt of a Case Managed Package/Carer Support Package and the package is unable to cover the cost of a short term respite need, we may be able to assist with funding. Applications for top up funding are applicable to Care Recipients who have a primary carer *living in Gippsland*.

***How to apply:***

The Case Manager/referer needs to complete:

* an S2S referral to **LCHS/Gippsland Wide/Top Ups & Mini Registraions for Events and Service Enhancement Apps**.
* complete the SCTT for the care recipient in client details in S2S
* attach the top up application form, with all fields completed
* send at least 4 weeks prior to date of **respite commencing** to allow time for consideration and processing.
* If you do not have access to S2S please submit your application to **Service Access** via email: ServiceAccessReferrals@lchs.com.au
* All written queries or advice following submission to be sent to **Carer Programs** via email: DisabilityAndCarerProgramsAdmin@lchs.com.au

***Important Information about the Application and Approval Process:***

* Lodgement of a top up application ***does not guarantee approval*** of a funding contribution.
* Funding requests will be considered on a monthly basis.
* Care arrangements and queries or follow up including all contact with the Carer/CR, will remain the responsibility of the Case Manager/referer.
* For residential respite funding, up to 50% only and a maximum of four weeks in a financial year will be considered. For applications over this amount, **evidence of financial hardship** must be provided.
* All changes to respite approved for funding should be communicated to Carer Programs asap so our records can be updated. Failure to notify changes may impact future considerations for top up funding.
* LCHS has a policy to make direct payment to service providers only. ***We are unable to provide direct reimbursement to carers/care recipients.***
* ***Funding agreements will be cancelled*** where a service provider fails to provide an invoice within 8 weeks of the respite taking place.
* We cannot fund respite retrospectively.

If you have any queries or wish to discuss current funding availability prior to sending your S2S referral please contact the **Clinical Lead Carer Programs on 1800 242 696.**