



Independent Living Skills Assessment

This form is to be completed by the client's health professional or support provider if the client has consented to the social housing provider's request for an independent living skills assessment. The Assessment will be used to assist the social housing provider in determining the client's ability to live independently without support, or with appropriate support in place. Please print in BLOCK LETTERS with a black or blue pen. For information or assistance with this form, phone **1800 422 322**, 24 hours a day, seven days a week. Please mark relevant boxes with a . If you need more room to answer any questions, please include details on a separate page and attach it to this form.

T File number

Client reference number

Name of social housing provider

Client consent

I, the undersigned (provide full details)

Title

Mr, Mrs, Ms, Miss

Last name or family name

Given name (s)

Unit/House number

Street/Avenue

Town/Suburb

Postcode

Phone

Mobile

Email address

Do hereby authorise and direct the following agency to provide information (including health information) relevant to my housing application.

Name of health professional/support worker/
carer

Name of agency

Address of agency

Street/Avenue

Town /Suburb

Postcode

Telephone number

I agree that only details which directly relate to my social housing application can be discussed. The release of information from the above agency is for the purpose of clarifying issues relating to my ability to live independently with or without support.

Full name (please print)

Signature

Date

DD / MM / YYYY

If applicable

Guardian's full name (please print)

Guardian's signature

Date

Independent living skills assessment

To be eligible for social housing, the client must be able to sustain a successful tenancy. This means that they must be able to meet the obligations of their tenancy agreement, without support, or with appropriate support in place. The following criteria need to be addressed in order to assist the social housing provider to determine whether social housing is the most appropriate housing option for the client's current housing and support needs.

Section A: To be completed by client's health care professional or support provider

1a. Does the client have Specialist Disability Accommodation (SDA) as a component of their NDIS support plan?

Yes

The client is not eligible for social housing and does not need to complete this form

No → Go to question 1b

1b. Will the client be assessed for SDA?

Yes

Provide details of the assessment to FACS when completed

No → Go to question 2

2. How long have you known or worked with the client?

3. Have you seen or worked with the client in a home environment?

Yes

No

4. In your professional opinion, is the client willing to engage or work with support services?

Yes

No

↓ Provide details below and go to Section B

Section B: Financial Management

5. Based on your professional opinion, does the client have the ability to manage their own finances?

Yes → Go to Section C

No → Go to question 6

6. Is the NSW Trustee and Guardian or the Public Guardian managing the client's finances?

Yes → Go to Section C

No → Go to question 7

7. Is a third party such as a family member managing the client's finances?

Yes

↓ Provide details below and go to Section C

No → Go to Section C

Section C: Property Care

8. Based on your professional opinion, does the client have the ability to maintain their home in a satisfactory condition (without support) and not cause property damage ? Yes → Go to Section D No → Go to question 9

9. Does the client have the ability to maintain their home in a satisfactory condition with support and not cause property damage? Yes No

10. Is the client currently accessing required support services? Yes No
Please list and describe support services being received below
Please provide the reasons why the client is not accessing required supports below

Section D: Personal Care

11. Based on your professional opinion, does the client have the ability to look after their basic day-to-day personal care needs without support? Yes → Go to Section E No → Go to question 12

12. Is a service provider such as Homecare supporting the client in this function? Yes No → Go to question 13
Please list and describe support services being received and go to Section E

13. Is the client being supported in this function by a carer? Yes No → Go to question 14
Please provide details below and go to Section E

14. If the client requires support to perform this function and is not accessing required supports, please provide reasons:

15. If required, does the client comply with medication support?

Yes → Go to Section E

No
Please advise what strategies are in place to assist with treatment

Section E: Social interaction

16. Based on your professional opinion, does the client have the ability to be responsible for their own conduct as well as the conduct of their visitors and not cause or permit nuisance or annoyance?

Yes
Please provide details below

No
Please provide details below

17. In your professional opinion, does the client have the ability to live in close proximity with others?

Yes
Please provide details below

No
Please provide details below

18. Please outline any other issues relevant to the client's ability to live independently that the social housing provider needs to take into consideration

Section F: Disability Support

19. Is the client a National Disability Insurance Scheme (NDIS) participant?

Yes

No → Go to question 20

Please provide name and contact details for the client's main support provider and attach client's NDIS support plan

20. Has the client been assessed as not eligible for NDIS?

Yes → Go to question 21

No → Refer client to NDIS for assessment

21. Is the client receiving support from a disability service provider?

Yes

No → Refer client to NDIS for assessment

Please provide name and contact details for the client's support provider

22. If required, does the client's NDIS support plan include funding for the following?

- | | | |
|------------------------|------------------------------|-----------------------------|
| Home modifications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Home and domestic care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lawn and garden care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Financial management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Personal care | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Behaviour management | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

If client has a formal behaviour support plan, please provide details

The assessment is now complete. Thank you for your cooperation.

Health/support worker name (please print)

Position

Signature

Date