# CHSP Home Modification Request Form

# Document No: IDG-HM-FRM-0121 Published Date: 20/07/2022

**Part A**

* **Before your client can access any government-funded aged care services, they must first be registered with My Aged Care.**
* **This form is for use by occupational therapists when assessing if home modifications are required to maximise a person’s safety and/or independence in their own home.**
* **Where this request is being provided as part of a CHSP Allied Health service please upload this form under “Other Attachments” in the My Aged Care Provider Portal. If difficulty loading all documents required, please send to** [**Homemods@indigosolutions.org.au**](mailto:Homemods@indigosolutions.org.au)**.**
* **Please note that no further action will be taken until such time as a home modification referral is received.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Details** | | | | | | | | |
| **Full Name**: |  | | **Phone** | |  | **DOB**: | |  |
| **Address of modifications**: |  | | | |  |  | |  |
| **Suburb/Town**: |  | | | **Postcode**: | | |  | |
| **Email for correspondence** |  | | | | | | | |
| **MAC ID Number:** | |  | | | | | | |
| **Home Modification Referral Code:** | |  | | | | | | |

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| **Client Profile** |
| **Living Situation**: |
|  |
| **Relevant Medical Information**: |
|  |
| **Mobility**: |
|  |

|  |  |
| --- | --- |
| **Recommendations** | |
| **1** | **Client Goal**: |
|  | **Recommendation**: |
|  | **What assistive technology / alternatives have been considered**: |
| **2** | **Client Goal**: |
|  | **Recommendation**: |
|  | **What assistive technology / alternatives have been considered**: |
| **3** | **Client Goal**: |
|  | **Recommendation**: |
|  | **What assistive technology / alternatives have been considered**: |
| **4** | **Client Goal**: |
|  | **Recommendation**: |
|  | **What assistive technology / alternatives have been considered**: |
| **5** | **Client Goal**: |
|  | **Recommendation**: |
|  | **What assistive technology / alternatives have been considered**: |
| **6** | **Client Goal**: |
|  | **Recommendation**: |
|  | **What assistive technology / alternatives have been considered**: |
| **7** | **Client Goal**: |
|  | **Recommendation** |
|  | **What assistive technology / alternatives have been considered**: |

**Part B**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Brief to Builder** | | | | | | |
| **Client Name:** |  | | | | | |
| **Address:** |  | | | | | |
| **Suburb/Town:** |  | |  | **Postcode**: | |  |
| **Contact Details:** |  | | | | | |
| **Date of OT Home Visit**: | |  | | |  | |
|  | |  | | | | |
| **Property Details**: | | *Building construction, presence of asbestos, multi-level, etc.* | | | | |
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|  | | | | | | |
| **Please include photos and diagrams to support this request. If proposed recommendations do not meet Australian Standards, please provide rationale for this.** | | | | | | |

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| **Home Modifications** | |
| **Item** | **Description, Specifications and Photos** |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |
| 7 |  |
| If significant changes are required to what is detailed on the brief, a new form and drawings may be required. | |

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| **Health Professional Details** | |
| **Name of Therapist:** |  |
| **Organisation:** |  |
| **AHPRA Number:** |  |
| **Contact number:** |  |
| **Contact email:** |  |

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| **Property Owner** | |
| ***Note****: Indigo Home Modifications will not proceed where another entity holds responsibility for changes to the home or similar support is provided through other programs e.g., Department of Veteran Affairs or WA Housing Authority.* | |
|  | As the owner of this dwelling, I understand and give permission for installation of the proposed modifications. |
|  | I understand that once installed, home modifications become the property of the homeowner and all ongoing repairs and maintenance are the sole responsibility of the property owner. |
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| **Owners Name:** |  | |
| **Date Signed:** |  |  |

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| --- | --- |
| **Signed**: |  |