SIL Expression of Interest Form

Thank you for considering InnerWorks Disability Services for your future home. Please complete the following information. All aspects of this form must be completed before consideration of transition into IWDS SIL Accommodation

Section One: *Details of participant.*

Personal Details:	
Name:	
Date of Birth:	
NDIS Participant Number:	
Gender:	Male Female Other I do not wish to disclose
Language:	English Other (specify)
Communication Method:	Verbal Other (specify)
Who do you currently live with?	
When would you like to move?	
I can share with opposite gender?	

Health Map:	
Primary Diagnosis:	
Other Diagnosis's Disability and Health:	
Sleeping Routine:	Active: Sleepover: Other Details:
Drug / alcohol / cigarette use – History or present:	No Yes – Specify. Are there supports currently in place?
Are there any other current health conditions?	

Are there any Historical health conditions?	

Circle of Support:	
Co-ordinator of Supports:	Name: Provider: Phone Number: Email:
Person Responsible Contact Information:	Name: Phone Number: Email:
Guardian Contact Information / Function Details:	Name: Phone number: Email: Function:
Trustee and Guardian:	No Yes Phone Number: Email:
Family Involvement:	Relationship: Name: Phone: Email: Relationship: Name: Phone: Email:

Additional Details:	
NDIS Plan:	Plan Dates: Agency Managed Plan Managed If Plan Managed, please provide Plan Manager details below: • Organisation: • Contact: • Email: • Contact Number:
SIL	SIL Funding Approved: • SIL: • Irregular Supports:

	• SIL Balance remaining: • SIL Ratio approved: (eg 1:1 2:, 1:2, 1:3 etc)
Restrictive Practices	Are there any restrictive practices in place? Chemical: Y N Mechanical Y N Seclusion Y N Physical Y N Environmental Y N

Section Two: *Current Assessments/Care Plans of Person being Referred.* ***PLEASE ATTACH TO EOI IF APPLICABLE***

(As per the NDIS, assessments need to be no older than 12 months)

☐ Current Court Orders eg CTO / AVO	☐ Medication Health Summary -	☐ Nutrition & Swallowing Assessment	☐ Individualised Care Plan (eg PEG/STOMA)
☐ Mental Health OT Report	☐ Diabetes Care Plan	☐ Bowel Management Plan	☐ Epilepsy Management Plan
☐ Functional Capacity Assessment	☐ Behaviour Support Plan	☐ Continence Assessment	☐

Section Three: *How to Best Support the Person being referred.*

Mobility Aids:		
☐ None required	☐ Walking Stick	☐ Four Wheeled Walker
☐ Wheelchair	☐ Electric Scooter	☐ Forearm Support Frame
☐ Other:		

Personal Care:			
☐ Independent	☐ Some Assistance	☐ Prompted	☐ Full Assistance
Showering Aids:			
☐ None required	☐ Shower Chair	☐ Shower Rails	
☐ Assistance to regulate water	☐ Shower Commode	☐ Non Slip Mat	
☐ Other:			

Toileting:			
☐ Independent	☐ Some Assistance	☐ Prompted	☐ Full Assistance
Toileting Aids:			
☐ None required	☐ Commode	☐ Urinal Bottle	
☐ Kylie Bed Mat	☐ Over Toilet Frame	☐ Grab Rail	
☐ Other:			

Transfers:

☐ Independent	☐ Some Assistance	☐ Prompted	☐ Full Assistance
Transfer Aids:			
☐ 1 x Staff Assist	☐ Sarah Steady	☐ Support Frame	
☐ 2 x Staff Assist	☐ Hoist & Sling	☐ Johnny Belt	
☐ Other:			

Meals/Fluids:			
☐ Independent	☐ Supervise	☐ Some Assistance	☐ Full Assistance
Meal/Fluid Aids:			
☐ None Required	☐ Modified Cutlery/Crockery	☐ Clothing Protector	
☐ Special Diet	☐ Nutrition & Swallowing Plan	☐ Other:	
☐ Thickened Fluids:-	☐ Level 1	☐ Level 2	☐ Level 3
☐ Left Handed		☐ Right Handed	

Domestic Activities:			
☐ Independent	☐ Some Assistance	☐ Prompted	☐ Full Assistance
Activities Requiring Support:			
☐ Shopping	☐ Meal Preparation	☐ Cleaning	
☐ Laundry	☐ Transportation	☐ Other:	

Sleep & Settling Routines:		
☐ Independent	☐ Some Assistance	☐ Night Checks ☐ Hourly ☐ Other:
Sleep/Settling Aids:		
☐ None Required	☐ Light on ☐ Light off	☐ Bed Rails up
☐ Kylie	☐ Door Open ☐ Door Closed	☐ Music/TV on
☐ Other		

Section Four: *Behaviours of Concern.*

BEHAVIOURS OF CONCERN:			
Property Damage	☐ Yes ☐ No	Self-Harm/Suicidal Ideations	☐ Yes ☐ No
Verbal Aggression	☐ Yes ☐ No	Medication Refusal	☐Yes ☐No
Physical Aggression	☐ Yes ☐ No	Illicit Drug Use	☐Yes ☐No
Alcohol Abuse	☐ Yes ☐ No	Smoker	☐Yes ☐No
Police Intervention	☐ Yes ☐ No	Admissions for Behaviour	☐Yes ☐No
Wandering	☐ Yes ☐ No	Hoarding:	☐Yes ☐No
Poor Hygiene:	☐ Yes ☐ No	Sexualised Behaviours:	☐Yes ☐No
Delusions:	☐ Yes ☐ No	Theft:	☐Yes ☐No
Other:	☐ Yes ☐ No	Other:	☐Yes ☐No

DESCRIPTION OF BEHAVIOURS OF CONCERN:		
Behaviours:	Examples:	Frequency:

Section Five: *Current Mainstream Supports.*

CURRENT MAINSTREAM SUPPORTS: Example Nursing													
Name:								Phone:					
Organisation:								Mobile					
Address:													
Email:													
Is the person being referred wanting to continue with current supports? ☐Yes ☐No													
Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		**Sunday**	
Start Time		**Start Time**		**Start Time**		**Start Time**		**Start Time**		**Start Time**		**Start Time**	
Hours		**Hours**		**Hours**		**Hours**		**Hours**		**Hours**		**Hours**	

CURRENT INFORMAL AND OTHER SUPPORTS: **e.g. Family Visits, Unaccompanied Community Access**	
Name:	Phone:
Relationship:	Mobile
Address:	
Email:	

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Is the person being referred wanting to continue with current arrangements? ☐Yes ☐No													
Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		**Sunday**	
Start Time		**Start Time**		**Start Time**		**Start Time**		**Start Time**		**Start Time**		**Start Time**	
Hours		**Hours**		**Hours**		**Hours**		**Hours**		**Hours**		**Hours**	

CURRENT COMMUNITY ACCESS: **e.g., day program, outings**	
Name:	Phone:
Organisation:	Mobile
Address:	
Email:	
Is the person being referred wanting to continue with current supports? ☐Yes ☐No	

Monday		**Tuesday**		**Wednesday**		**Thursday**		**Friday**		**Saturday**		**Sunday**	
Start Time		**Start Time**		**Start Time**		**Start Time**		**Start Time**		**Start Time**		**Start Time**	
Hours		**Hours**		**Hours**		**Hours**		**Hours**		**Hours**		**Hours**	

Section Six: *Consumables used by the Participant.*

Consumables used:	
☐ Wrap around pads – Quantity per day:	☐ Pull up pads – Quantity per day:
☐ Pad inserts ☐ All ☐ Night pad only	☐ Wipes
☐ Bed bath wipes	☐ Bluey's
☐ Gloves	☐ Sanitiser
☐ Catheter tubes	☐ Catheter bags ☐ Night ☐ Day
☐ Colostomy bag/pouch	☐ Skin care cream/foam
☐ Other:	☐ Other:

Section Seven: *Further Information relevant to the person being referred. Eg. Allergies, Likes, Dislikes, Family etc.*

Next steps:

I would like to be considered for a placement in a InnerWorks Disability Services home that suits my needs and meets my goals for Supported Independent Living.

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I currently have SIL funding and want to transfer from my current provided to InnerWorks Disability Services OR I have capacity to explore SIL in my current plan.

I would like InnerWorks Disability Services to organise a SIL quote for me to reside and be supported in a InnerWorks Disability Services SIL home.

NAME OF PERSON SIGNING APPLICATION:

DATE:

ROLE:

SIGNATURE

A MEMBER OF OUR TEAM WILL BE IN TOUCH AS SOON AS POSSIBLE. THANK YOU!