Home Care Check-in Referral Form

The Home Care Check-in pilot program aims to minimise risk of vulnerable people who are receiving aged care services and experiencing social isolation. The program is consent driven, meaning that clients of the program need to be informed about its purpose, and consent to participate.

Please complete this form either with or on behalf of your client and forward to the Home Care Check-in Team aras@agedrights.asn.au.

If you have any questions about this form or the referral process, please contact the Home Care Check-in Team on 08 8232 5377.

Referral Criteria

☐ Client must be registered for, or already receiving in home Aged Care Services and living in the Adelaide Metropolitan area.

AND

Has one or more of these risk factors (tick all that apply):

☐ Living alone/socially isolated	☐ Experiencing grief or loss
☐ Heavily reliant on one provider or carer	☐ Cognitive decline or impairment
☐ Few or no family or friends that regularly check in on them	☐ Limited mobility or mobility issues
☐ Difficulty communicating or being understood	☐ Inability to drive

Please note priority will be given to clients falling within the following specialist groups as defined in the Aged Care Act 1997. Priority groups (tick all that apply):

☐ Aboriginal and Torres Strait Islander people	☐ Veterans
☐ People from Culturally or Linguistically Diverse backgrounds (CALD)	☐ Care Leavers (Forgotten Australians)
☐ People experiencing homelessness or at risk of becoming homeless	☐ People from LGBTIQ+ community
☐ People who are specified in the allocation principles	☐ People living with a mental illness
☐ People who experience dementia or cognitive decline	☐ People who live with a disability
☐ People who are financially or socially disadvantaged	

This referral has been discussed with the person. They have given consent for the referral and for a Home Care Check-In Advocate to contact them: Yes ☐ No ☐

Client Details

Name:		
Preferred name:		
Date of birth:	Gender:	Pronouns:
Phone:	Email:	
Address:		

Referrer Details

Name:	Date of referral:
Phone:	Organisation:
Email:	

What home care services does the client currently receive? (which provider)	
GP name and contact details (if known)	
Any other informal and formal supports (if known)	
Communication supports needed (if any)	
Reason for referral (Include any information that will help ARAS to support the client)	