****

**Instructions**

Please use this form to describe the capabilities and needs of a person who has requested home services because they are unable to perform their usual household tasks due to their transport accident injuries. The assessment will result in a plan for services to support the person in managing household activities for a defined length of time, when a review will determine further needs.

# Section 1

## TAC client details

|  |  |
| --- | --- |
| First name |   |

|  |  |
| --- | --- |
| Last name |   |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |   | Date of accident |  / /  |

|  |  |
| --- | --- |
| Date of birth |  / /  |

|  |  |
| --- | --- |
| Street name and number |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |   | Post code |   |

|  |  |
| --- | --- |
| Client phone number |   |

|  |  |
| --- | --- |
| Client email address |   |

|  |  |
| --- | --- |
| Key contact if not client |   |

|  |  |
| --- | --- |
| Key contact phone number |   |

|  |  |
| --- | --- |
| Relationship of key contact |   |

(e.g. parent, partner, guardian)

|  |  |
| --- | --- |
| Date of assessment |  / /  |

# Section 2

## Current situation

### Social situation

Briefly describe accommodation type, stability/permanency of accommodation, whether living alone or with
others, whether child/partner/extended family with a disability or special needs living in the same house,
caring responsibilities, pets.

|  |
| --- |
|   |

Are there cultural or other considerations that impact upon the person’s preferences for the provision of home services? Please outline.

|  |
| --- |
|   |

# Section 3

## Pre-accident duties and home management

Outline pre-accident capabilities and usual duties, as reported by the person or representative.

(e.g. day-to-day activities and household management)

|  |
| --- |
|   |

Pre-accident and current duties performed by other household members.

|  |  |  |
| --- | --- | --- |
| Household member | Pre-accident duties | Is there any change in these duties? Give reasons.  |
| Spouse/partner |   |   |
| Children |   |   |
| Others |   |   |

|  |  |
| --- | --- |
| Did the person receive home services/community supports or had been assessed for these services prior to the transport accident? (e.g. home help, family assistance) |  |
|   |

**If yes**, provide reasons why these were required and details of service level recommended.

|  |
| --- |
|   |

|  |  |
| --- | --- |
| Have these pre-accident support services recommenced? |   |

**If no**, please state reason(s).

|  |
| --- |
|   |

|  |  |
| --- | --- |
| Was the person in receipt of a pension and/or benefits prior to the accident?(e.g. NDIS, Aged Pension, My Aged Care, Centrelink Disability Support Pension)  |  |
|   |

**If yes**, please provide the details of the disability or reason for benefit.

|  |
| --- |
|   |

What is the impact of pre-existing and non-accident related impairments on the person’s functioning?

|  |
| --- |
|   |

### Details of current home environment

Describe the size of the house and/or garden. Outline the overall size of the house including the number of bedrooms, bathrooms and shared living areas.

| Topic  | Comments | Insert photo(s) if applicable |
| --- | --- | --- |
| Details of pre-injury home(where relevant) |   |  |
| Current home type(e.g. single-storey house) |   |  |
| Number of bedrooms |   |  |
| Number of bathrooms |   |  |
| Number of living areas |   |  |
| Type of flooring carpet/tiles |   |  |
| Access to home (external/internal, steps) |   |  |
| General presentation (e.g. garden, surrounds; outline size of lawn if relevant)  |   |  |
| Does the person own standard and safe domestic/garden appliances and equipment?**If no**, how did they manage pre-injury?  |   |  |
| Additional comments regarding home environment (e.g. assistive technology, home modifications in place) |   |  |

Insert photos of the house if possible.

|  |
| --- |
|  |

# Section 4

## Current capabilities

Consider the person's capabilities in the following areas: physical, cognitive, sensory, communication and behavioural/emotional issues and prognosis.

|  |
| --- |
|   |

Comment on how the person’s current capabilities are impacting on their ability to manage their home responsibilities.

Note how performance relates to injuries from the transport accident.

|  |  |  |
| --- | --- | --- |
| Area of function | Current capabilities  | Anticipated change in capabilities (include time frame) |
| Personal care |   |   |
| Domestic/ home based activities  |   |   |
| Community based tasks, including work, study and recreation/leisure |   |   |

### Statement of goals

Briefly outline the person’s goals or recovery plan.

|  |
| --- |
|   |

In the table below, outline current capabilities related to day-to-day activities and responsibilities for which the person requires assistance. Please include:

1. A task analysis and evaluation of the person’s capability with the specific task. Include **domestic tasks** (e.g. house cleaning, meal preparation, laundry, cyclical cleaning, gardening) or **community tasks** (e.g. grocery shopping).
2. The person’s current limitations related to their transport accident injuries. Consider physical, cognitive, behavioural/emotional issues and environmental barriers to participation.
3. Strategies you recommend to meet the person’s goals. Consider assistive technology/equipment, modifying the task, or providing education sessions regarding the use of assistive technology and/or strategies to increase their level of independence. Consider a graded re-introduction to the task over a specific period of time. **If funded support is required, please include the amount of time required for each task**.

| 1. Task observed and task analysis

(if not observed, explain reasoning) | 1. Current capability and any limitation in relation to transport accident injuries
 | 1. Strategies/Support recommended to meet the person’s goals and independence
 |
| --- | --- | --- |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |

# SECTION 5

## Home services plan

Summarise from the table in section 4 above.

|  |  |  |  |
| --- | --- | --- | --- |
| Task | Type and frequency of required support  | Time required (hours per week) | Length of time support required and suggested review time |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

# section 6

## Assistive technology recommended to meet person’s goals

Include clinical justification and any alternative options to meet the person’s goals, with details of all items of
equipment trialled. (including the specific item recommended)

Please note if an Assistive Technology Assessment and Recommendations is required for complex or high-cost items. Refer to the TAC aids/equipment provision policy.

|  |  |  |  |
| --- | --- | --- | --- |
| Equipment/Supplier details (note if hire or purchase and cost) | Length and location of trial, if relevant | Clinical justification, including impact on level of funded support | Time frame for use/review |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |
|   |   |   |   |

# section 7

## Other providers contacted

Provide a summary of information received from any service provider contacted (e.g. physio) to confirm the time
frame for any activity restrictions currently in place. Include attempted contacts with other providers to support recommendations.

|  |  |
| --- | --- |
| Provider contacted |   |

Comments/Recommendations obtained from providers

|  |
| --- |
|   |

# section 8

## Other relevant information to support decisions and recommendations

|  |
| --- |
|   |

# section 9

## Summary of plan

Provide the length of time support is required and a suggested review time. For example, ‘Support required for six months with a review to be conducted by this time’. Note any comments about the plan from the person or their representative*.*

|  |
| --- |
|   |

# SECTION 10

## PROVIDER DETAILS

|  |  |
| --- | --- |
| Provider name, address, email and phone number(Type details or insert image of practice stamp) |  |

|  |  |
| --- | --- |
| SWEP credentialing level |   |

|  |  |
| --- | --- |
| Days/hours available |   |

|  |  |
| --- | --- |
| SignatureInsert image (jpg/png) of signature.(Or print, sign and scan the form) |  |



|  |  |
| --- | --- |
| **Date** |  / /  |

****

**Submitting this form**

Email your completed form to your TAC claims manager or to info@tac.vic.gov.au with the client’s TAC claim number in the subject line. Please also attach any supporting documentation.

**Privacy**

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law
to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)