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**Instructions**

Complete this form when the TAC requests a review of a person’s capabilities and the supports required to enhance the person’s participation in their personal, home and community activities. The assessment can include physical, cognitive and emotional functioning as well as the environmental aspects and assistive technology that enhance participation. Please familiarise yourself and make your recommendations in line with the TAC’s Assisted Accommodation and Daily Support fee guidelines.

# 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)

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| --- | --- | --- |
| Date of previous Supported Accommodation Review of Capabilities | / / |  |

Reason for referral

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Risk advice for site visit. Precautions or concerns, if known.

(Provider to carry out own home visit assessment of risks)

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# Section 2

## Current supported accommodation facility

Include details on the name of the facility, number of residents and number of staff rostered during a 24-hour period, including overnight staff.

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| Services | Funding source | If other, please provide name of the provider | Current hours of additional 1:1 services in addition to shared support provided by the supported accommodation facility |
| --- | --- | --- | --- |
| Personal care |  |  |  |
| Therapy support |  |  |  |
| Community access |  |  |  |
| Allied health assistant |  |  |  |
| Community based  rec/leisure supports  (e.g. neighbourhood house) |  |  |  |
| Community group programs |  |  |  |
| Other: (Please specify) |  |  |  |

Add comments regarding other funding.

(e.g. SIL or SDA)

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# Section 3

## Contributors to the Review

Comment on the person’s ability to engage. Include any strategies used to support the person to communicate if there are communication barriers.

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Other people contributing to the review, and information used, in this Occupational Therapy Supported Accommodation Review of Capabilities.

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| --- | --- | --- | --- |
| Name | Relationship to person  e.g. family member, friend, support worker, TAC staff | Contact phone number | Means of information provision  Report, verbal contact or present during  the assessment. Include date of contact. |
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# section 4

## Pre-accident function

What was the person’s pre-accident functionin regard to personal, domestic and community activities?Consider the person’s usual duties, frequency of completion and how the tasks were managed.

(e.g. help from family members, friends or neighbours)

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# Section 5

## Report on funded program

What is the person’s level of satisfaction with their current TAC-funded program? Include whether they are achieving goals for participation in desired activities, and a summary of the key life areas and activities they would like to focus on in the future.

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# Section 6

## Current Status and Performance

Summarise the person’s current capabilities. Include relevant details, noting how capabilities relate to injuries from the transport accident.

### Injuries and health

Note any updated information regarding TAC-accepted medical conditions, pre-accident injuries or illnesses, and   
non-TAC related conditions**.**

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### Home, living and social situation

Outline the relationship with other people living at the residence, any recent changes and stability of current situation. Is the person satisfied in their current situation? Any anticipated changes?

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### Physical, sensory, mobility and transfers

Include indoor/outdoor mobility, upper and lower limb function, balance, strength/endurance and any required splinting or assistive technology.

(e.g. hoists, powered wheelchairs)

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### Cognitive and behavioural

Include memory, insight and distractibility.

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### Psychological and emotional

Note any comments from the person, their carers or other providers about relationships and managing life stressors.

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### Communication, hearing, vision, tactile and swallowing

Note any difficulties, support or special requirements.

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### Rest, sleep and hygiene

Note the person’s or carer’s report on sleep routine, hours of sleep and rest and any difficulties reported.

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### Cultural issues and preferences to be considered in assessment and in provision of services

Note any cultural considerations, religious beliefs and/or other factors that impact on decisions regarding management of supports.

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# Section 7

## Assistive Technology

Please provide details of the person’s current assistive technology and any maintenance or repair requirements.   
List any items the person no longer requires. Do these items require retrieval by the TAC?

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# Section 8

## Summary of activities

In the tables below, identify the amount of support time required for the person to perform their ADLs. Please include:

1. The periods of time during which the house staff need to provide **1:1 support that cannot be met** under the shared care model – e.g. direct and uninterrupted supervision, or physical assistance (1:1 in-house attendant care).
2. The activities and times during which **shared care (SC)** can be provided. Shared careis support that can be safely provided to a number of residents at the same time (i.e. safely leave one person for a period to attend to another person).
3. The **therapy support (TS)** activities for which there are allied health developed and monitored goals.
4. The activities for which attendant care is required for **community access (CA)**.

### Personal care activities

| Activity  e.g. showering, feeding, grooming, toileting | Type of assistance required  e.g. verbal prompting, supervision, physical assistance | How this support is to be provided  e.g. in- house 1:1AC, shared care, therapy support (external SW) | Is person’s status likely to change? | Current hours | Recommended funded hours |
| --- | --- | --- | --- | --- | --- |
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|  |  |  |  |  |  |
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| Total | | | |  |  |

Comment on personal care status including clinical justification for attendant care in addition to shared support   
if required.

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### Domestic activities, including household tasks

| Activity  e.g. meal planning, laundry, cleaning/tidying personal space | Type of assistance required  e.g. verbal prompting, supervision, physical assistance | How this support is to be provided  e.g. in- house 1:1AC, shared care, therapy support (external SW) | Is person’s status likely to change? | Current hours | Recommended funded hours |
| --- | --- | --- | --- | --- | --- |
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|  |  |  |  |  |  |
| Total | | | |  |  |

Comment on domestic activities including clinical justification for attendant care in addition to shared support   
if required.

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### Community activities

Include recreation, leisure and community access.

(e.g. community group programs)

| Activity  e.g. shopping, attending gym, banking | Type of assistance required  e.g. verbal prompting, supervision, physical assistance | How this support is to be provided  e.g. in- house 1:1AC, shared care, therapy support (external SW), community access (CA)  or community group program (CGP) | Is person’s status likely to change? | Current hours | Recommended funded hours |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
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| Total | | | |  |  |

Comment on community activities including clinical justification for 1:1 attendant care if required.

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### Other activities

Include, for example, vocational, education, therapy support, self-management or organisation.

| Activity  e.g. therapy support, vocational/education, self-management and organisation | Type of assistance required  e.g. verbal prompting, supervision, physical assistance | How this support is to be provided  e.g. in- house 1:1AC, shared care, therapy support (external SW), community access (CA)  or community group program (CGP) | Is person’s status likely to change? | Current hours | Recommended funded hours |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Total | | | |  |  |

Comment on other activities including clinical justification for 1:1 attendant care if required.

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# Section 9

## Overnight support requirements

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| --- | --- |
| Are you recommending inactive or active overnight support? |  |

Provide details of the person’s identified overnight care needs in line with the [TAC Attendant Care Provider Guidelines](https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines/provider-guidelines/attendant-care-provider-guideline).   
Outline the type, frequency and time taken to complete specific tasks required overnight.

Note: an 8 hour inactive (sleepover) shift is inclusive of 1 hour of support, not necessarily provided consecutively.

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Are there any strategies or assistive technology available to improve the person’s independence overnight?

For example, switch-activated alarm monitoring, alternating air mattress, continence management review, staff training.

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Provide clinical justification for the recommended overnight support needs identified above.

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# Section 10

## Assessments and standardised measures

Please note where applicable any standardised assessments, outcome measures or clinical guidelines used to support and/or justify recommendations. Attach scores or summary if relevant. For example, SCI Level/ASIA, CANS, COPM, SMAF, PSFS, AMPS, DACSA. Attach report summary and scores where relevant. Refer to notes for further information if needed.

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# Section 11

## Proposed weekly support planner

Please indicate where TAC-funded supports are used during the week, including shared care provided by the Supported Accommodation facility and additional 1:1 in-house attendant care, personal care (PC), shared care (SC),community access (CA), therapy support (TS), community group programs (CGP), etc.

|  | Morning | Afternoon | Evening | Total hours per support type  per day |
| --- | --- | --- | --- | --- |
| **Example** | 7-9 am 1:1 in-house attendant care (bowel care, showering dressing):  2 hours  9-10 am TS (walking practice): 1 hour | 1-3 pm SC (home based rec activities: 2 hours  3-4 pm CA (personal shopping): 1 hour | 6-7 pm SC (dinner preparation with other residents): 1 hour | 1:1 in- house attendant care:  2 hours  SC: 3 hours  CA: 1 hour  TS: 1 hour |
| **Monday** |  |  |  |  |
| **Tuesday** |  |  |  |  |
| **Wednesday** |  |  |  |  |
| **Thursday** |  |  |  |  |
| **Friday** |  |  |  |  |
| **Saturday** |  |  |  |  |
| **Sunday** |  |  |  |  |
|  | Total hours for week | | |  |

# Section 12

## Ongoing need to reside in Supported Accommodation

Please provide your opinion if continued funding for supported accommodation is requested. Provide clinical justification as to why the person needs to live in 24-hour supported accommodation. If placement is transitional   
(e.g. independent living model) please state goals and projected timeframes that supported accommodation may be required. Please confirm review date.

Recommendations

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# Section 13

## Recommendations for further assessment

Include assistive technology, home modifications and vehicle modifications

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| --- | --- |
| Do you recommend further assessments or interventions for this person? |  |

**If yes**, please complete the following table.

| Proposed assessment  or intervention | Provider type |
| --- | --- |
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# Section 14

## Other relevant information and comments to support decisions and recommendations

Include specific discussions with other providers regarding the recommendations such as concerns with how the care/support is being provided, e.g. conflict of interest, quality of care, opportunities to increase safeguarding on   
the program.

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# Section 15

## Summary and recommendations

Provide a summary of recommendations of what support hours should be funded as attendant care, in addition to support provided under the shared care model of support. For further information of what is included under the Daily Support Fee for shared care provision, please refer to the [TAC Attendant Care Provider Guidelines](https://www.tac.vic.gov.au/providers/working-with-tac-clients/guidelines/provider-guidelines/attendant-care-provider-guideline).

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| --- | --- |
| Have you discussed this Occupational Therapy Supported Accommodation Review of Capabilities  with the person or the person’s representative and have their consent to supply the TAC with the  information collected? |  |
|  |

# section 16

## Provider details

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

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

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

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

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Description automatically generated

|  |  |
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| Date | / / |

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Description automatically generated**

**Submitting this form**

Email your completed form to your TAC claims manager or to [info@tac.vic.gov.au](mailto: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)