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**Instructions**

Use this form to review supports funded to help a person manage day-to-day tasks in their home. If the assessment was requested by the TAC, review the OT Referral for Assessment for information about specific areas to be addressed.

# 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 TAC referral | / / | Date of home services review | / / |

# Section 2

## Review of home service requirements

Statement of goals: briefly outline the person’s goals / recovery plan.

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| --- |
|  |

|  |  |
| --- | --- |
| Have there been any changes in social situation since the Home Services Assessment and Plan  was established? |  |
|  |

**If yes**, outline current social situation. Provide details of any changes since initial plan.

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Have there been changes in the person’s capabilities (physical, cognitive, behavioural/emotional) and/or environmental barriers to participation? |  |
|  |

**If yes**, note how performance relates to injuries from the transport accident and the details of change since the initial assessment. How does this impact on level of support for home services or equipment required?

|  |
| --- |
|  |

|  |  |
| --- | --- |
| Have there been changes in the capacity of other household members to carry out duties? |  |

**If yes**, note current and pre-accident duties performed by other household members and provide reasons for   
these changes.

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| --- |
|  |

Are there cultural or other considerations to be considered in the provision of home services? Please outline.

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| --- |
|  |

# Section 3

## Any other activities assessed

|  |  |
| --- | --- |
| Are there other support requirements not identified in the initial assessment? |  |

For example, personal care, domestic/home based activities, community based tasks, including work, study and recreation/leisure.

|  |  |  |
| --- | --- | --- |
| 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 |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |

# Section 4

## Other service provider/s 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 5

## Revised Home Services Plan

### Funded services

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

# Section 6

## Other recommendations

Provide any other relevant information or recommendations for other assessments.

|  |
| --- |
|  |

### Assistive technology recommended

|  |  |  |
| --- | --- | --- |
| Item of equipment | Hire/purchase  and cost | Length of time support required and suggested review time |
|  |  |  |
|  |  |  |
|  |  |  |

# Section 7

## Summary of plan

Provide the length of time support is required and 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 8

## 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) |  |

Icon

Description automatically generated

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

**Icon

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)