Community Living Support Service - Referral Form

The Community Living Support Service (CLS) is a recovery oriented support service providing outreach support for adults experiencing issues with their mental health.

The service is underpinned by Wellways Community Recovery Model and principles of community inclusion and works to provide the following outcomes:

- Improved daily living skills and capacity to live independently in the community
- Improved understanding of mental health issues and developing strategies for recovery
- Improved physical health
- Improved capacity to maintain a home
- Improved relationships and community participation
- Engagement in education, training and/or employment

The eligibility criteria for the Community Living Support Service is as follows:

- 16 years of age or over
- Diagnosis of a mental health issue that is impacting on the person's ability to live independently
  OR
  a) In the case of a young person, where a formal diagnosis is absent, eligibility will include functional impairment identified by a mental health professional
  b) of Aboriginal descent, experiencing a social and emotional wellbeing concern. A diagnosable mental health condition is not required to receive support.
  c) in the case of refugee and asylum seekers, experiencing psychological distress, mental ill health and functional impairment. A diagnosable mental health condition is not required to receive support.
- Resides within the catchment area of Illawarra Shoalhaven
- Receiving ongoing support from or eligible for support from Illawarra Shoalhaven LHD Mental Health Service or other community-based clinical support willing to collaborate with Wellways. eg. Psychologist, Psychiatrist, ISLHD Mental Health Primary Clinician, GP
- Consent to participate in the program and information sharing across key partners.

Length of access to the program will be determined by need, however it is anticipated that most people will access support for 12 months or less – exiting the program after strong community links and natural supports have been developed to support this process.

Referral Process

Please complete the attached CLS referral form and forward to referrals.cls.islhd@wellways.org

All referrals are reviewed and considered based on eligibility. Referrals will be reviewed at an intake and review meeting which occurs monthly.

We will be in contact with you to inform you of the outcome of the referral.

If you would like further information, please contact us:

call (02) 9101 5900

email us referrals.cls.islhd@wellways.org

Intent to apply for CLS and consent for release of information

The Community Living Support Service is delivered in partnership between Wellways and Illawarra Shoalhaven Local Health District (ISLHD). To ensure we are able to provide coordinated support Wellways and ISLHD will share information that is relevant to your care. The Privacy Act requires the person applying for this service to sign this form giving their consent for the release of their information and details.

Referrals are reviewed at the Community Living Support Service (CLS) and the Housing and Accommodation Support Initiative (HASI) intake and review meeting. Key partners at this meeting include representatives from Wellways, ISLHD Mental Health Service, HASI providers (Neami - Illawarra and Grand Pacific Health - Shoalhaven) and local Housing Providers (Department of Communities & Justice / The Housing Trust /Southern Cross Community Housing)

I, _____ give my consent to Wellways to review my referral with the above mentioned and seek supporting information from the following people concerning relevant information related to this application:

□ Local Health District _____

□ Medical Service / Professional _____

□ Housing Provider _____

□ Other (please detail) _____

□ Family/Carer_____

NSW Government Health Release of Information:

It is a requirement of the CLS / HASI services that ISLHD / community based clinical support provide relevant information to inform decision making regarding eligibility, recovery planning and safety. This may include: Mental Health Care Plans, Mental Health Reviews / Current Assessments, Risk Assessments and Discharge Summaries.

If you not currently engaged with the ISLHD Mental Health Service, we can support you to meet with one of their staff to discuss your eligibility.

I consent to my information being used for de-identified statistics for program evaluation.

I agree for Wellways staff to call me and / or the referring person or agency in order to update my information and to see if I am still interested in this support.

Applicant's signature: _____ Date: _____

Referrer's signature: _____ Date: _____

Verbal Consent – referrer use only

Should only be used where it is not practicable to obtain written consent.
I have discussed the proposed referrals with the person being referred or authorised representative and I am satisfied that they understand the proposed uses and disclosures, and has provided their informed consent to these.

Referrer's signature: _____ Date: _____

Staff Name: _____

Position: _____

Referrer's Contact Details: _____

Details of person being referred

Legal Name:	
Preferred Name:	
Date of Birth:	Gender: Male ☐ Female ☐ Non Binary ☐
Phone:	Email:
Address:	

Please tell us about yourself

What would you like help with? How would you like us to support you?

Are there other areas that you would like support with e.g. any particular challenges or barriers, exploring new opportunities or working towards goals in education, employment or accessing the community?

Predicted hours of support required:

☐ Daily / Several times a week ☐ Weekly ☐ Fortnightly

What are your current living arrangements?

☐ Public Housing ☐ Living with friends / family ☐ Boarding House

☐ Community Housing ☐ In Hospital ☐ Homeless

☐ Owned Home ☐ Emergency Housing ☐ Unsuitable Accommodation

☐ Private Rental ☐ Correctional Facility ☐ Other – please specify

☐ Support required to maintain tenancy

Your information continued

Country of Birth:

Preferred Language: Interpreter Required: YES ☐ NO ☐

Do you identify as being: Aboriginal ☐ Torres Strait Islander ☐
Aboriginal and Torres Strait Islander ☐ Neither ☐ Not Stated ☐

Do you access an Aboriginal Health Service / Aboriginal Medical Service: YES ☐ NO ☐

Do you identify as being: A Refugee ☐ An Asylum Seeker ☐

Do you identify as being: ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Transgender ☐ Intersex

Next of kin / primary carer information

Name:	Relationship:
Phone:	Email:
Address:	

Health Information

Do you have a diagnosed mental illness: Yes ☐ No ☐ Suspected ☐

Primary diagnosis:

Do you have any other co-existing factors impacting on your mental wellbeing?
☐ Intellectual Disability ☐ Brain Injury / Neurological
☐ Alcohol and / or other Drugs (specify) ☐ Physical health / medical conditions (specify)

Have you made / been supported to make an application for the NDIS for Psychosocial Disability Support? Please provide details.

Are there any current orders in place?
☐ Community Treatment Order ☐ Forensic Order ☐ Court Orders
☐ Community Based Detention / Parole ☐ Guardianship ☐ Financial Orders

Other services that you currently access/receive support from

Service Type	Contact Name	Contact Details	Frequency of support
Allied Health Worker			
Psychologist			
Psychiatrist			
GP			
Housing Worker			
Other (specify)			
Other (specify)			

Have any other referrals been made? / Are you on the waitlist for any other services?
Please specify

Hospital Admission – Mental Health inpatient admissions in the last 24 months:

Hospital	Date of Admission	Length of Admission If current – expected date of discharge

Risk Assessment:
Please note – a copy of the ISLHD risk assessment is to be attached. A Wellways risk assessment form will be emailed to community based referrers / clinical supports.

☐ Suicide and self-harm ☐ Vulnerability (Exploitation/ Reputation) ☐ Alcohol / other drugs

☐ Aggression and violence ☐ Self-neglect ☐ Environmental risks

☐ Sexual Safety ☐ Domestic / Family violence ☐ Other (please specify)

Please provide context below:

Are there any risk factors that indicate preferred staff allocation?

Is there any other relevant information that you would like to share

For example, is there information that you would like to provide, that will help us to support you with your health and safety e.g. current medical conditions, thoughts of self-harm, family concerns, drug and alcohol use issues.

If you are receiving support to make this referral, please provide details

Name of person providing support:	
Relationship:	Service:
Phone:	
Signature:	
Date referral submitted:	

Supporting Documents - Checklist

For referrals from ISLHD Mental Health Team - Please ensure the following documents are attached:

- ☐ Mental Health Care Plan
- ☐ Mental Health Review/ Mental Health Assessment form
- ☐ Discharge Summary (where relevant)
- ☐ Mental Health Risk Assessment

For more information, call Wellways (02) 91015900 or email completed referral to referrals.cls.islhd@wellways.org