# Attendant Care Services Request (ACSR)

Use this form for Lifetime Care Scheme and the Workers Care Program

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| This form outlines the attendant care services that the person requests icare to pay for. The completed form must be submitted to: Care-Requests@icare.nsw.gov.au. All ACSRs must related to a current Care Needs Assessment Report (CNAR) or Care Needs Review Report (CNRR). |
| Person’s Details |
| **Name** | **Participant No. or Claim No.** |
|       |       |
| **Address** |
|       |
| **Contact Name** | **Contact Phone** |
|       |       |
| **Injury** |
| [ ]  TBI | [ ]  SCI | [ ]  Other (specify):       |

|  |
| --- |
| Form completed by |
| **Name** |
|       |
| **Relationship to participant** |
| [ ]  Case Manager | [ ]  Coordinator, RCM, CLF, Approved Care Assessor | [ ]  Other (specify):       |
| **Email** | **Phone** |
|       |       |

## Service to be Provided by

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| **Has an attendant care provider been selected?** |
| [ ]  **Yes – specify provider:**      **If no, has the person been provided with attendant care provider panel list?** [ ]  **Yes** [ ]  **No** |

## Dates

|  |
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| **Date of this request** |
|       |
| **Proposed dates for this care period cannot extend beyond end date of the relevant CNAR or CNRR.**  |
| **From** | **To** | **Number of weeks** |
| Click or tap to enter a date. | Click or tap to enter a date. |       |

**There is a maximum 16 week period for the initial care program.** Services cannot extend beyond the interim participation period end date noted in the referral.

## Request for attendant care services:

Support Worker skills (refer to Guidelines on ACIA website www.acia.net.au - Provision of Paid Attendant Care and Nursing in the Community)

|  |  |  |
| --- | --- | --- |
| Skill | Required | Task for which required |
| Injury related core support worker competencies | [ ]  |       |
| Brain injury specific support worker competencies | [ ]  |       |
| Spinal cord injury specific support worker competencies | [ ]  |       |
| Registered nurse | [ ]  |       |
| Other (specify): | [ ]  |       |

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| **Have any restrictive practices been identified or recommended that require authorisation?** |
|       |

Other important skills for support workers (e.g. ability to transport participant, language skills, or experience with children/adolescents)

|  |  |
| --- | --- |
| Skills | Task for which required |
|       |       |

Recommendations for person focused training

List any essential training that is unique to the person’s needs (e.g. specific support strategies, therapy program or use of specialised equipment.

|  |  |  |  |
| --- | --- | --- | --- |
| Training required | Training hours per support worker | Number of workers | Who will provide training (e.g. OT, physio, PBSP) |
|       |       |       |       |
|       |       |       |       |

Travel for treatment and rehabilitation This section is for travel in the support worker’s car, or for the cost or fares for the support worker to accompany the person on public transport. Refer to the Travel to attend treatment and rehabilitation services information sheet P05 resource on the icare website.

|  |  |  |
| --- | --- | --- |
| Treatment/rehabilitation service requiring travel | Mode of transport(support worker’s car or public transport) | Km or fares per week(add # of trips / frequency of travel if known) |
|       |       |       |
|       |       |       |
|       |       |       |
| Other relevant information:       |

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| **Risk factors**Please list any risk factors in relation to the provision of attendant care services that need to be considered. These may relate to the safety of the person or support worker or others.  |
|       |

Services being requested by the person (and/or family member or nominated person)

|  |  |
| --- | --- |
| Attendant Care | Number/frequency (per month or week) |
| Support worker hours (excluding inactive sleepovers) |       |
| Second support worker (hours) |       |
| Inactive sleepover (number of nights per week) |       |
| Registered nurse (hours) |       |
| Travel for treatment and rehabilitation (km or fares) |       |
| Training requested (No. hours per worker) |       |
| Domestic services (only include if domestic services are being delivered by a different attendant care provider (and therefore not included in the hours above. Specify provider: |       |
| Garden/home maintenance Specify provider:  |       |

## Recommended hours of attendant care

### Are the hours/services being requested the same as the hours recommended by the assessor in the CNAR or CNRR?

|  |  |
| --- | --- |
| [ ]  **Yes** | [ ]  **No** |
| **If less – is there any risk to the participant arising from this reduction of hours?** |
|       |

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| **If more – describe the reasons and what the services/hours are being requested for** |
|       |

Assessor comments on the requested hours

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## Service provider declaration

The person has been involved as much as possible in the development of this request in collaboration with their family member or nominated person if necessary. The person (and family member or nominated person) agrees with this request.

|  |  |
| --- | --- |
| **Name** | **Date** |
|       |       |

## Timetables

### For services recommended by Care Needs Assessor in the Care Needs Assessment or Care Needs Review Report

### For services requested by participant (if different to above)

### For services completed and approved by icare (sent to Attendant Care Provider & included on certificate)

Please refer to Guide to completing Care Needs Assessment Report for more information on completing the timetable/s

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** | **Tasks & time required** |
| **Early morning** |       |       |       |       |       |       |       |
| **Morning** |       |       |       |       |       |       |       |
| **Afternoon** |       |       |       |       |       |       |       |
| **Evening** |       |       |       |       |       |       |       |
| **Overnight** |       |       |       |       |       |       |       |
| **Total hours of care per day** |       |       |       |       |       |       |       |
| **Non-weekly tasks and time required** |
|       |

NB: Domestic and gardening services should only be scheduled to occur Monday – Friday during usual business hours.