Complete this form to summarise the client’s understanding of available services and preferred support options that will help them to develop independent living, community, and employment opportunities.

When you’ve finished, please return this form to the ACC contact person noted in the service referral form.

Part A - Background

|  |  |
| --- | --- |
| 1. Client details | |
| Client name: | Claim number: |
| Date of birth: | Address: |

|  |  |  |  |
| --- | --- | --- | --- |
| 2. Client’s family/whānau and support attending meetings with the client (if required) | | | |
| List names of family/whānau or support people and indicate whether they attended the meeting with the client | | | |
| Name | Relationship | Role | Attended meeting with client |
|  |  |  | Yes  No |
|  |  |  | Yes  No |
|  |  |  | Yes  No |
|  |  |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| 3. Client representative with legal authority to act (if required) | | |
| Name: | Relationship to client: | Attended meeting with client:  Yes  No |
| Phone number: | Email address: | Postal address: |

|  |  |  |  |
| --- | --- | --- | --- |
| 4. Supplier details | | | |
| Organisation name: | | Email address: | |
| Contact name: | Job title: | | Phone number: |

|  |  |
| --- | --- |
| 5. ACC details | |
| ACC staff member: | ACC office: |

Part B – Independent facilitation summary

|  |  |  |
| --- | --- | --- |
| 6. Client’s understanding of the support and providers available | | |
| Complete the relevant information below. | | |
| The client… | Yes | Describe what was done to achieve this. |
| understands what support is available in their community |  |  |
| identified local cultural, community and employment support |  |  |
| identified natural & mainstream disability support |  |  |
| identified disability support providers |  |  |

|  |
| --- |
| 7. Support and provider options identified |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Provide a summary of the services, providers and any support options you’ve discussed and agreed with the client.  Copy and paste additional lines as required. | | Funded by | | | |
| Description of the service   * What services can the client access? * What would be delivered by the service? * Who would deliver the service including the role of LmL suppliers in the delivery, if any? * Are there any direct costs outside of any LmL service delivery? | What would be achieved by attending  Referring to the risks identified in the referral identify any other issues or concerns that will be reduced or removed. | Client/Family | Community | ACC - LmL | ACC - Other |
| *Woodworking at the New Plymouth Men’s Shed. There is no membership charge.*  *The LML supplier would support for the first few visits to support the building of the routine and relationships then withdraw.* | *The client would interact with other people with an interest in woodworking. Learn new skills.* |  |  |  |  |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |

Part C – Declaration and signature

|  |  |  |  |
| --- | --- | --- | --- |
| 8. Client (tick for yes) | | | |
| I have discussed my agreed preferences with the provider. | | I understand and agree with the information in this summary. | |
| Other: | | | |
| Client signature: | Name: | | Date signed: |

|  |  |  |  |
| --- | --- | --- | --- |
| 9. Client representative with legal authority to act (if needed) | | | |
| I have discussed the client’s preferences with the client & provider | | I have discussed the information related to this summary with the client & provider | |
| Other: | | | |
| Signature: | Name: | | Date signed: |

|  |
| --- |
| 10. Copy of report |
| A copy of the Living my Life Independent facilitation report has been given to the client:  Yes  No |

|  |  |  |
| --- | --- | --- |
| 11. Provider | | |
| I have provided an accurate and complete report of the client’s participation needs based on the information provided at the time of the assessment. I have worked together with the client and considered all the options available to meet the client’s needs and participation outcomes. | | |
| Provider signature: | Name: | Date signed: |

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