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| Please return to: [highneedspackage@homelessnessnsw.org.au](mailto:highneedspackage@homelessnessnsw.org.au)  *This form is to be used for periodic reviews of full High Needs Packages (HNP), and requests for reallocations or additional support items in One-Off Funding Grants (OOFG).* | | | | | |
| **Section 1** | **Individual** | | | **Type of Review** | Choose an item. |
| **Full name** |  | | |
| **District** | ​​District​ | | | **Date review submitted** |  |
| **D.O.B.** |  | **THCI Number** |  |
| **Section 2** | **Referring Agency** | | | **Section 3** | **Community Housing Provider** |
| **Organisation** | ​​Support Provider​ | | | **Organisation** | **​​**Housing Provider**​** |
| **Person making referral** |  | | | **Person creating invoice** |  |
| **Job title** |  | | | **Job title** |  |
| **Email** |  | | | **Email** |  |

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| **Section 4** | **Long term plan and transition to mainstream service provision** | | | |
| **Goal** | | **Action** | | **Timeframe** |
|  | |  | |  |
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|  | |  | |  |
| **Funding stream** | **Application submitted** | **Application successful** | **Briefly note any barriers** | |
| NDIS | **YES**  **NO**  **N/A** | **YES**  **NO**  **N/A** |  | |
| HASI | **YES**  **NO**  **N/A** | **YES**  **NO**  **N/A** |  | |
| DSP | **YES**  **NO**  **N/A** | **YES**  **NO**  **N/A** |  | |
| AGED CARE | **YES**  **NO**  **N/A** | **YES**  **NO**  **N/A** |  | |
| OTHER (specify) | **YES**  **NO**  **N/A** | **YES**  **NO**  **N/A** |  | |
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| **Section 5** | | **High Needs funding approved to date** | | | | | |
| If the funding has been exhausted, please indicate this by marking the box in the final column. | | | | | | | |
|  | **Service Item** | | **Date Approved** | **Date Commenced** | **Reason why not commenced** | **Total amount approved** | |
| 1. |  | | Enter a date. | Enter a date. |  |  |  |
| 2. |  | | Enter a date. | Enter a date. |  |  |  |
| 3. |  | | Enter a date. | Enter a date. |  |  |  |
| 4. |  | | Enter a date. | Enter a date. |  |  |  |
| **TOTAL FUNDING APPROVED TO DATE (Excl GST)** | | | | | |  | |

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| **Section 6** | **How well have High Needs funding and Together Home supports met the individual’s needs?** |
| Provide information as to how the HN funding approved to date has affected the individual’s progress, and/or detail any issues or challenges that have affected the delivery of the services funded to date. | |
| Summary | |

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| **Section 7** | **Why are you submitting this review?** | | |
| **To reallocate previously approved funding** | | **To request additional High Needs funding** | **To close existing HNP or OOFG package** |
|  | | | |
| **Complete to Section 10.** | | **Complete to Section 10.** | **End of form. Thank you.** |

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| **Section 8** | **Additional High Needs funding request** | | | | |
| Please create a budget outline below for additional items you wish to be considered for High Needs funding. | | | | | |
| **Intervention** | **Frequency** | **Service Provider** | **Fees per encounter / service** | **Duration / taper schedule of service** | **Total cost** |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| **TOTAL** | | | | |  |

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| **Section 9** | **Linking High Needs funding request to transition plan and goals** | | |
| Please explain how each intervention requested above aligns with the long-term goals (Section 4) and/or current support needs that necessitated this referral. Please describe actions that have already been taken or considered before High Needs funding, to support the panel to understand the need for this request. | | | |
| **Why have you selected this intervention / service provider?** | | **Goal / Support Need** | **Actions considered and /or currently being taken to achieve this goal** |
| 1. | |  |  |
| 2. | |  |  |
| 3. | |  |  |

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| **Section 10** | **Current supports in place** | | | |
| Please detail all current services and community supports who are working alongside this person. These may be through Together Home, inclusive of previous HN funding, as well as the interpersonal, community, mainstream or specialist services they may currently engage with. | | | | |
| **Need** | | **Intervention** | **Support Provider** | **Frequency** |
|  | |  |  |  |
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