Commonwealth Home Support Program

Negotiated Contribution Review and Outcomes Form

THE CITY of Unley

Note: This form will only be accepted if all questions are answered, and relevant evidence provided where requested

Client:		**Client ID:**		**Date:**	

1. Clearly outline below the reason/s for this *Negotiated Contribution Review*

2. Do you receive the Aged Pension	☐ Yes	☐ No
• If **YES**, add the Pension number: **CRN:**		
• If **NO**, please note eligibility criteria has not been met, do not proceed filling in this form		
3. Do you have any other sources of income (i.e., rental property, part time job, money making hobbies etc)	☐ Yes	☐ No
• If **YES**, provide further information below:		

4. Please clearly outline your approximate monthly income not including your Aged Pension payment: *$

*If total amount of Income recorded at question four (4), exceeds $180 per fortnight (single) or $320 per fortnight (couple), please note eligibility criteria has not been met, do not proceed filling in this form

If you answer yes to any of the questions below, further details are required at each question and at question 12 providing further information i.e., if you have answered yes to question 9, you need to outline exactly what these other expenses are (i.e., taxi fares, etc.) so a fully informed decision can be determined. Forms not filled in correctly will be returned for further information.

5. Is your home either rented or mortgaged	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
6. Do you have any other loans or financial expenses?	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
7. Do you find it difficult to pay bills like electricity, gas, water?	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
8. Do you have any significant regular medical and/or medication costs?	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
9. Do you have any other regular monthly expenses?	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
10. Do you receive other support services	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
11. Is there a reduced fee or waiver in place for the above service/s	☐ Yes	☐ No
• If **YES**, clearly enter the approximate monthly cost:	$	
Total monthly expenses	$	

12. Is there any other information you would like to include to support this request?

OFFICE USE ONLY				
Approval Granted:			☐ Yes	☐ No
If no, provide reason/s:				
☐ 10% waived	☐ 20% waived	☐ 30% waived	☐ 40% waived	☐ 50% waived
☐ 60% waived	☐ 70% waived	☐ 80% waived	☐ Other (specify below)	
Revised hourly rate for each applicable service				

SERVICE	CURRENT HOURLY FEE	NEW HOURLY FEE
1.	**$**	**$**
2.	**$**	**$**
3.	**$**	**$**
4.	**$**	**$**

Information collected and verified as accurate by:	
Name:	**Title**:
Signature:	**Date**:
Approval granted by:	
Name: Angela Morrison	**Title**: Team Leader Community Support and Wellbeing
Signature:	**Date**:

CLIENT ACCEPTANCE		
I accept the new reviewed level of contribution for my CHSP service/s	☐ Yes	☐ No
I have received information about my right to appeal if I am not satisfied with this decision	☐ Yes	☐ No
I understand that if my circumstances do not change, this review decision remains in place for a period of 12 months and will be applied across all other CoU CHSP services I may access within this period. Should my circumstances change significantly, I can request another review to be carried out at this time, because it is important that the services, I receive remain affordable to me.	☐ Yes	☐ No
I have provided the information on this form believing it to be an accurate and true account of my current financial situation	☐ Yes	☐ No
Any other comments:		
Client Name: @CLIOTHERNAME@ @CLISURNAME@		
Signature:	**Date**:	

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Kaurna Country