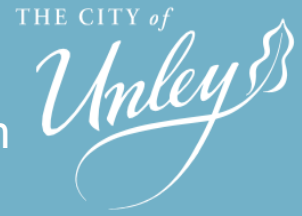


# Commonwealth Home Support Program

## Negotiated Contribution Review and Outcomes Form



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

Client:	Client ID:	Date:
<b>1. Clearly outline below the reason/s for this <i>Negotiated Contribution Review</i></b>		
<b>2. Do you receive the Aged Pension</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, add the Pension number: <b>CRN:</b></li> <li>If <b>NO</b>, please note eligibility criteria has not been met, do not proceed filling in this form</li> </ul>		
<b>3. Do you have any other sources of income</b> (i.e., rental property, part time job, money making hobbies etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, provide further information below:</li> </ul>		
<b>4. Please clearly outline your approximate monthly income <u>not</u> including your Aged Pension payment: *\$</b>		
*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.		
<b>5. Is your home either rented or mortgaged</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>6. Do you have any other loans or financial expenses?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>7. Do you find it difficult to pay bills like electricity, gas, water?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>8. Do you have any significant regular medical and/or medication costs?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>9. Do you have any other regular monthly expenses?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>10. Do you receive other support services</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>11. Is there a reduced fee or waiver in place for the above service/s</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If <b>YES</b>, clearly enter the approximate monthly cost: \$</li> </ul>		
<b>Total monthly expenses</b>		<b>\$</b>
<b>12. Is there any other information you would like to include to support this request?</b>		

**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:** @CLOTHENAME@ @CLISURNAME@**Signature:****Date:***Funded by the Australian Government Department of Health.**Although funding for this program has been provided by the Australian Government, the material contained herein does not necessarily represent the views or policies of the Australian Government.**Kaurna Country*