

Application for a Needs Assessment

Live the life you imagine

How to apply

Before you get started, you may find it useful to visit www.accessability.org.nz to learn about the Needs Assessment process and who is eligible.

1. Fill in this form to apply for a Needs Assessment. You can apply for yourself, or you can fill this form out on behalf of a family member, friend or client.
2. Send your application by email to referrals@accessability.org.nz. You can also post it to or visit your local office. Our contact details are below.

A large print version of this application is also available. Please visit our website to download it or request a copy from your local office.

If you have any questions, please contact us.

What if I have had a Needs Assessment with AccessAbility before?

You don't need to fill in this form unless we ask you to do it again. If your life has changed and you would like to be re-assessed early, please contact us.

Contact us

Otago / Southland office

otago@accessability.org.nz
Level 1, Burns House
10 George Street
Dunedin 9016

Taranaki office

contact@accessability.org.nz
Visit: Level 1, Kings Building
36 Devon Street West
Post: PO Box 8377
New Plymouth 4342

Whanganui office

wanganui@accessability.org.nz
244 Victoria Avenue
Whanganui 4500

1. Your details

Full name:

Phone number:

Email address:

Mobile phone number:

Birth date:

Gender:

Ethnicity

New Zealand Maori

Asian

Iwi:

Pacific Islander

New Zealand European/Pakeha

Other:





<p>Who do you live with?</p> <p><input type="checkbox"/> Family</p> <p><input type="checkbox"/> Alone</p> <p><input type="checkbox"/> My partner</p> <p><input type="checkbox"/> Friends</p> <p><input type="checkbox"/> Other:</p>	<p>Your address (include postcode):</p>
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Are you a New Zealand Resident?

Yes

No

<p>Which language do you prefer to speak?</p>	<p>Would you like an interpreter for any meetings or conversations with the AccessAbility team?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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An alternative contact for you. This could be your parent, caregiver, partner or another person you choose.

Name: _____ Phone number: _____

Relationship to you: _____ Email Address: _____

2. Your medical information

<p>Name of your doctor (GP):</p>	<p>National Health Index (NHI) number (if you know it):</p> <p>Community Services Card number (if you know it):</p>
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My disability is:

If it's the first time you have worked with us, please ask your doctor or specialist to fill out a 'Confirming your disability' form. This is available on our website: www.accessability.org.nz



I also live with these medical/mental health/accident-related conditions:

3. Reasons for application

Describe the reasons for your application. What do you need support with because of your disability?

Describe any sensitive issues that AccessAbility staff need to know about when working with you. Are there any topics that you find hard to communicate about? Do you have any sensitivity to loud noises, unfamiliar people or other things?

If we meet with you at your address, are there any safety or security issues we need to think about? For example: your dog, young children, keeping the gate or door locked etc.

What other people or organisations are you working with? This includes places you currently receive support from.

Specialist:

ACC:

Social worker:

Paediatrician:

Therapist:

Agencies:

Psychologist:

Other:

How urgently do you feel that you need support in your current situation?

Non urgent (within one week)

Semi urgent (within
2 days)

Urgent (within 1 day)



3. Consent details

Tick the option that applies best to you:

- I am filling out this form myself and I give AccessAbility permission to use the information.
- I am filling out this form for someone else and have their consent.
- I am filling out this form for someone else and do not have their consent because:

Full name of person filling out form:

Relationship to disabled person (if filling out this form on someone's behalf):

Signature:

Contact email:

Date:

Contact phone number:

Organisation (if referring person):

5. Hospital discharge information (if recently discharged)

Discharge date:

Are short-term support services in place?

Yes, between these dates:
_____ and _____

No

How often do you need assistance with personal care?

Less than daily

Daily

More than daily

Do you need night care?

No

Sometimes

Every night

Is your home suitable for your immediate and ongoing support needs?

Yes

No, because:

Thank you for completing this application. We will respond as soon as we can.

