



2011 Quality of Life Grants

1) Your details

Name			
Residential address			
Postal address			
Telephone number			
Email address (if applicable)			
Date of Birth		Gender	Male <input type="checkbox"/> Female <input type="checkbox"/>
Country of Birth	Australia <input type="checkbox"/> Others (please specify) _____		
Do you identify as Aboriginal or Torres Strait Islander?		Yes	No
Do you require interpreter services?		Yes	No
Have you received a compensation payment as a result of acquiring a disability?		Yes	No
Do you intend to claim or do you have a current claim for a compensation payment as a result of acquiring a disability?		Yes	No

2) Details of contact person/guardian for this application (if not you)

(If you have a legally appointed guardian, the contact person must be the guardian)

Name of preferred contact	
Residential address	
Postal Address	
Telephone number	
Email address (if applicable)	

3) Your most effective method of communication.

(Please tick the answer appropriate to you)

- Spoken Language (effective)
- Sign Language (effective)
- Other effective non-spoken communication
- Little, or no effective communication
- Child less than 5 years old (not applicable)

4) Your current living and financial situation

(Please tick the answer appropriate to you)

Living arrangements	Alone <input type="checkbox"/>	With others <input type="checkbox"/>
	With Family <input type="checkbox"/>	
Residential Setting (Please tick the appropriate box)	<input type="checkbox"/> Private Residence <input type="checkbox"/> Housing ACT <input type="checkbox"/> Residence with in an Aboriginal community <input type="checkbox"/> Domestic-scale supported accommodation facility <input type="checkbox"/> Supported accommodation facility <input type="checkbox"/> Boarding house/private rental <input type="checkbox"/> Independent living unit within a retirement village <input type="checkbox"/> Residential aged care facility <input type="checkbox"/> Psychiatric/mental health community care facility <input type="checkbox"/> Hospital <input type="checkbox"/> Short term crisis, emergency or transitional accommodation <input type="checkbox"/> Public place/temporary shelter <input type="checkbox"/> Other	
Labour force status (Please tick the appropriate box)	Employed <input type="checkbox"/>	Not in the labour force <input type="checkbox"/>
	Unemployed <input type="checkbox"/>	
Income (Please tick the appropriate box)	Disability Support Pension <input type="checkbox"/>	Other Income <input type="checkbox"/>
	Other pension or benefit <input type="checkbox"/>	Nil income <input type="checkbox"/>
	Paid employment <input type="checkbox"/>	Not known <input type="checkbox"/>
	Compensation payments <input type="checkbox"/>	

5) Your primary disability and any other significant disabilities

(Please tick only one primary disability)

Primary disability

Other disability

Intellectual		
Specific learning/ADD - other than Intellectual		
Autism - including Asperger's Syndrome		
Physical		
Acquired brain injury		
Neurological - including epilepsy & Alzheimer's Disease		
Deaf/blind - dual sensory		
Vision		
Hearing		
Speech		
Psychiatric		
Developmental delay – only valid for a child aged 0-5 years		
Pease provide the name / type diagnosis of your primary Disability (if known)		

6) How often do you need support in the following life areas?

Please indicate the level of help or support required for each life area (rows a - i) by ticking only one level of help/support (columns 1 - 5)					
LIFE AREA	1) Unable to do or always need help/support in this life area	2) Sometimes need help/support in this life area	3) Does not need help/support in this life area but use aids or equipment	4) Do not need help/support in this life area and do not use aids or equipment	5) Not applicable
a) Self-care e.g. personal care					
b) Mobility					
c) Communication e.g. making self understood					
d) Interpersonal interactions and relationships					
e) Learning, applying knowledge and general tasks					
f) Education					
g) Recreation and leisure, and handling money					
h) Domestic life					
i) Employment					

7) Please describe what kind of funded support would improve your quality of life.

Describe the support/item that you are seeking (please include the name of the provider if relevant)	How much/ how many hours/how often	Requested funds (up to \$5000)
Total		

8) How will this grant improve the quality of your life?
 (Tick appropriate box for your answer)

	Yes	No
Will help you to access the community?		
Will help you to participate within the community?		
Will assist you to improve your skills and abilities?		
Will increase the number of choices in your life?		
Will increase your sense of personal respect?		
Will strengthen the capacity of your family or carers?		
Will reduce any risks to your health and safety?		

Comments:

9) If you are seeking a grant for equipment or modification. Has an Occupational Therapist or other relevant therapist recommended the equipment or modifications for you?

Yes/ No

If yes: please include Name and Contact details.

10) Is this the most cost effective item or service to address your support needs?

Yes / No

If yes: why? If no: indicate why this model is preferred.

**11) Will there be any additional costs in relation to this item in the future?
If so, how will you meet the cost**

Agreement and Consent Form

(Please read, sign and date the agreement below)

Consent

I consent to Disability ACT using the information in this application to determine my priority for funding for the Quality Of Life grants process, and beyond this process to plan for services and unmet need.

I consent to Disability ACT confirming the appropriateness of the equipment / modification with my named therapist in question 7 (if applicable).

I consent that if I am allocated funds through this grants process Disability ACT may contact me within the following 12 months to ascertain what difference these funds have made to me.

I/we agree to the terms in the Consent and certify that the information supplied in this application is true and correct:

Name: _____ Signature: _____

Date: _____

Relationship to applicant if not the applicant: _____

Media Contact List (Please tick appropriate answer to you)

I agree that if allocated a grant, Disability ACT may contact me in the future to ask if details about my grant may be given to the media. I acknowledge that I am not obliged to accept such a request, and may refuse to participate in media events at any time.	Yes	No
	<input type="checkbox"/>	<input type="checkbox"/>

Person assisting in filling in this application: (if applicable)

Name	
Agency or relationship to applicant	
Postal address	
Telephone number	
Signature	
Date	

Applications should be returned to
The Grants Officer, Quality of Life Grants, Disability ACT
GPO Box 158 Canberra City ACT 2601