



ABORIGINAL PRIVATE RENTAL ASSISTANCE PROGRAM (APRAP)

INTAKE PERSONS DETAILS

DATE: ____/____/____

NAME:

PHONE:

CLIENTS CULTURAL IDENTITY:

GENDER:

Aboriginal

TSI

Both

Unknown

| | | |
|------------------------------|--|---------------------------|
| CLIENT'S NAME | | |
| DATE OF BIRTH | | |
| RESIDENTIAL ADDRESS | | |
| POSTAL ADDRESS IF APPLICABLE | | |
| PHONE NUMBER/S | | |
| CAN A MESSAGE BE LEFT? | YES <input type="checkbox"/> NO <input type="checkbox"/> | ALTERNATIVE PHONE NUMBER: |

| CHILDS/PARTNER'S NAME | DATE OF BIRTH | ADDRESS |
|-----------------------|---------------|---------|
| | | |
| | | |
| | | |

COMMUNICATION DETAILS

| INTERPRETER REQUIRED | VISUALLY IMPAIRED | HEARING IMPAIRED | ILLITERATE | OTHER |
|--|--|--|--|----------|
| YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | IDENTIFY |





HAS A DISCLOSURE BEEN MADE? YES NO TO WHOM?

L17 (FAMILY VIOLENCE) YES NO DATE: ____/____/____

RISK ASSESSMENT COMPLETED? YES NO CURRENT IVO/AVO: YES NO

RISK LEVEL: HIGH MEDIUM LOW

SAFETY PLAN IN PLACE: YES NO

RELEVANT INFORMATION/SUMMARY:

| IDENTIFIED ISSUES/SUPPORTS REFERRALS REQUIRED | YES | NO | SERVICE PROVIDER IDENTIFIED |
|--|-----|----|-----------------------------|
| Medical | | | |
| Dental | | | |
| Optical | | | |
| Financial | | | |
| Housing | | | |
| Mental Health Concerns | | | |
| General Counselling | | | |
| Drug and Alcohol | | | |
| Gambling | | | |
| Legal Issues | | | |
| Behavioural/Aggression | | | |
| Wellbeing | | | |
| Community Correction Order <small>(identify community area for support to complete order/support for application)</small> | | | |
| Parenting issues/support required | | | |
| Maternal Child and Health Nurse | | | |
| Child Care | | | |
| Kinder | | | |
| Education | | | |
| Access Visitations | | | |
| Safety Plan | | | |
| Intervention Order <small>(to support client to complete online)</small> | | | |
| Other - | | | |



CLIENTS SIGNATURE:

INTAKE PERSONS SIGNATURE:

CLIENTS CONSENT FORM COMPLETED: YES No

| | |
|--|--|
| ALLOCATED WORKER: | |
| SERVICE PROVIDED: | |
| DATE REFERRAL SENT TO SERVICE PROVIDER | |

For Office Use Only

- APRAP Assessment Checklist
- APRAP Application Form
- Client's ID's
- Bank/Centrelink Income Statement

