

YHARS After Care Funding Application

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| Date of Referral: / / | |
| Client Details | |
| Given Name: | Cultural Affiliation: |
| Middle Name: | <input type="checkbox"/> Aboriginal |
| Surname: | <input type="checkbox"/> Torres Strait Islander |
| Phone Number: | <input type="checkbox"/> Both |
| Address: | <input type="checkbox"/> Other _____ |
| Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other | <input type="checkbox"/> Australian South Sea Islander |
| Date of Birth: / / Age: | Please select all that apply: |
| <input type="checkbox"/> year estimated | <input type="checkbox"/> Current/ Past Corrective Service involvement |
| Country Of Birth: | <input type="checkbox"/> Disability |
| First Language At Home: | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Culturally and Linguistically Diverse | <input type="checkbox"/> Parent/ Pregnancy |
| | <input type="checkbox"/> Dependents living with client |
| | <input type="checkbox"/> Engaged in school/training |
| Client Eligibility – ALL MUST APPLY | |
| <input type="checkbox"/> Aged between 17-21 years | |
| <input type="checkbox"/> Transitioning or exited from Child Safety after being subject to a Child Protection Order | |
| <input type="checkbox"/> Homeless, or at risk of homelessness | |
| Referring Organisation Details | |
| Organisation: | |
| Name of person completing referral: | |
| Address: | |
| Phone: | Fax: |
| Email: | |
| Brokerage Application | |
| How much YHARS support is being sought? \$ _____ | |
| (Up to a limit of \$3,500). You do NOT have to access the total amount in one transaction; however, all remaining funds must be accessed prior to the young person turning 22 years of age. | |
| Note: The following option is NOT available to Government Organisations. The subcontracted NGO service can submit a proposal to conduct up to 15hrs of case planning with an eligible young person for approval @ SACS 4.4 (QLD Community Service and Crisis Assistance Award 2008) this is to assist in payment for processing this application. | |
| Payment Options | |
| YHARS purchases goods/services directly on behalf of young person through your organisation, unless otherwise negotiated. (Please attach quotes with the Goal Plan) | |
| Assessment and Transition Planning | |
| Has the young person accessed Transition From Care funding (TFC) from the Department of Communities, Child Safety and Disability Services, Transition to Independent Living Allowance (TILA) or any other Government Agency? | |
| <input type="checkbox"/> Yes (Please specify) | <input type="checkbox"/> No |
| Details: | |

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| What Office of the Department of Communities, Child Safety and Disability Services was your client last case managed by? | |
| Details: | |
| Client gives consent for YHARS team to contact Child Safety for confirmation? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| To your knowledge is there a current transition from care plan in place? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Referral Assessment | |
| Please check box or boxes to indicate your client's status: | |
| <input type="checkbox"/> This purchase supports case plan goals | |
| <input type="checkbox"/> This purchase would withstand public scrutiny | |
| <input type="checkbox"/> All alternative options were explored before purchasing goods/services | |
| <input type="checkbox"/> Expenditure demonstrates value for money and is the best use of resources to meet case goals | |
| <input type="checkbox"/> To your knowledge, your client has not received a similar service from another agency | |
| Declaration | |
| I declare that the information provided in this form, including all supporting documents, is correct to the best of my knowledge. I acknowledge that YHARS monies received and spent otherwise than in accordance with the current version of the YHARS Guidelines, or if received as a result of incorrect, fraudulent or misleading information being included and/or submitted with this form must be immediately repaid to the YHARS national Service Provider or the Department of Communities, Child Safety and Disability Services if required to do so by notice in writing by the YHARS National Service Provider or Department of Communities, Child Safety and Disability Services. | |
| I verify that all YHARS monies will be spent in accordance with the YHARS Guidelines, to purchase goods and/or services that provide necessary relief for the young person. | |
| I understand and acknowledge that the YHARS After Care Program is a brokerage service only, with no capacity for client contact (except in the case of self-referral). | |
| I acknowledge that upon receipt of goods purchased for the client by YHARS that all responsibility for care, maintenance, upkeep and security pass to the client. | |
| I agree to have my client sign an "Acknowledgement of Receipt of Goods" form after receiving any goods/services purchased on their behalf and return to CTC within 7 days. | |
| Signature: | Date: / / |

Please note: Email this completed YHARS After Care Funding Application form to yhars@ctcgld.com.au. You will then shortly be contacted to confirm your client's eligibility. You will then be provided with a Goal Plan form which you will need to complete and return with quotes for processing.

YHARS Guidelines: <https://www.communities.qld.gov.au/resources/communityservices/youth/youth-housing-reintegration-service-guidelines.pdf>