# Referral Form

(Financial Crisis and Material Aid - Emergency Relief)

**ER 01**

Accessible Diversity Services Initiative Limited

The Referral Form should be completed in consultation with the client(s) and the referring agency/referrer MUST obtain consent from the client(s) before referral.

**SERVICE TYPES**

- People in immediate financial crisis by providing financial or material aid
- Referrals
- Self-Reliance Support

**ELIGIBILITY**

- **Restricted** to people unable to pay their bills or at the imminent risk of not being able to do so
- Western Sydney Region Settlement Consortium's ER service is for people who reside in the below LGAs:

  Blacktown, Blue Mountains, Burwood, Camden, Campbelltown, Canada Bay, City of Ryde, Cumberland, Fairfield, Hawkesbury, Hornsby Shire, Inner West, Liverpool, Municipality of Hunter's Hill, Parramatta, Penrith, Strathfield, The Hills Shire, Wollondilly Shire

## Referring Agency Details

**Agency *:** _____

**Contact Person *:** _____ **Position:** _____

**Phone *:** _____ **Email *:** _____

## Client Details

**Surname *:** _____ **Given Name *:** _____

**Gender *:** ☐ Female ☐ Male **Phone *:** _____

**Address *:** _____
(Number and Street)

**Suburb *:** _____ **Post Code *:** _____

**Language Spoken at Home** (If NOT English) ***:** _____

**Does the client require interpreter *:** ☐ Yes ☐ No

## Family Details

| Full Name | Relationship | DOB | Gender | Other Financial Information (Payslips, Centrelink Income Statement, etc.) |
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| **Reason for Referral** (Please give as much information as possible) |
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| **Referrer's Declaration** |
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| By signing this Referral Form, I have obtained consent, either in verbal or written format, from the client detailed above to release all information contained in this Referral Form to the Accessible Diversity Services Initiative Limited (ADSI). |
| ☐ I have attached a copy of my client's Consent to be sent with this referral |
| **Referrer Name *:** (Please Print) _____ **Referrer Signature *:** _____ **Date *:** _____ |

| **Please send the completed form to ADSI via** | **Office Use Only** | |
|---|---|---|
| **Email:** er@adsi.org.au (Preferred), or<br>**Fax:** 02 8737 5599 | **Date Received:** | |
| | **Date Assessed:** | |
| | **Assessment Outcome:** | ☐ Eligible ☐ Not Eligible |
| | **Referral Allocated To:** | |