Residential care providers use this form to request an extension to residential support or change in a resident’s support needs. Please submit extension requests at least 2 weeks before the planned discharge date.

A registered health professional holding a current annual practicing certificate must complete sections 6-8.

Send the completed form to [claimsdocs@acc.co.nz](mailto:claimsdocs@acc.co.nz).

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| 1a. Resident details | |
| **If completing this form in hard copy, attach BRADMAR sticker over the relevant details.** | |
| Resident name: | Date of birth: |
| Address: | |
| Contact number: | NHI number: |
| Date of admission to residential care: | |

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| 1b. Authorised alternative contact details | |
| Contact name: | Contact number: |
| Relationship to resident: | |

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| 2. Request purpose |
| Tick all that apply, fill in sections 3 to 5 and then complete the relevant sections listed below. |
| What is being requested:  Extension of time for interim residential care (sections 6, 7, 8 and 11)  Extension of time for long term residential care (sections 6, 7, 8 and 11)  Transfer (home or alternative facility) with injury-related supports (sections 9 and 11)  Variation in the funding of residential care (sections 10 and 11) |

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| 3. Facility details | |
| Residential care home/facility name: | |
| Address: | |
| Vendor ID: | Contact name: |
| Contact number: | Email address: |

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| 4. General practice/practitioner details | |
| Organisation name: | |
| GP name: | Contact number: |

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| 5. Injury details | |
| ACC45 number: | Date of injury: |
| Injury diagnosis at the time of transfer to residential support: | |
| List the resident’s relevant treatment history (including surgery) or attach clinical notes: | |

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| 6. Pre-injury medical or disability details | |
| Sections 6-8 must be completed by a registered health professional.  Note any pre-existing conditions that might affect the resident’s ability to rehabilitate. | |
| Hypertension or  Hypotension  Osteoporosis  Arthritis  Mental health diagnosis  Heart disease  Type 1 diabetes  Type 2 diabetes | Cognitive impairment  Hearing impairment  Visual impairment  Total knee joint replacement  Left  Right  Total hip joint replacement  Left  Right  Chronic obstructive pulmonary disorder |
| Mobility issues, eg if walking aid used, specify details: | |
| Neurological condition, specify details: | |
| Other conditions, specify details: | |

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| 7. Extension of time requests | | | |
| What residential support service is currently being provided?  Short term care (including interim care)  Long term care | | | |
| Has this resident’s residential care previously been extended?  Yes  No | | | |
| Original planned discharge date: | | New discharge date (if relevant): | |
| What is the planned extension duration? | | | Daily rate: |
| What is the injury related need for ongoing Residential Support Services? Provide the rationale for your answer: | | | |
| Why is an extension necessary?  Inaccessible home supports  Behavioural support needs | Lack of natural supports  Housing limitations (eg homelessness, rurality with no care available) | | |
| Other (please state): | | | |
| Intended discharge destination at the completion of this extension (if relevant):  Hospital  Home (usual place of residence)  Other private residence  Discharge address: | | | |

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| 8. Planned interventions | |
| Advise what rehabilitation or interventions are being put in place to help the resident recover from their injury, or maximise their independence, during the service period. | |
| Intervention | Planned date | |
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| Is any equipment or property modification required, which would allow the resident to return home? Please provide details: | |

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| 9. Discharging to home or alternative facility with additional supports required | | | |
| Complete this section if a resident requires additional injury-related support after discharge. | | | |
| Support requirement | Pre-injury need | At time of transfer to RSS | Current state |
| Household tasks (eg laundry) | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Showering/ bathing | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Toileting | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Meal preparation | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Transport | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Medication management | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Wound management | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Social integration | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Cognitive tasks of daily living | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Mobility around residence | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Childcare / other caring responsibilities | Independent  Assistance needed  Funded  Self-funded | Independent  Assisted | Independent  Assisted |
| Other, specify details: | | | |
| List any risks or hazards a provider needs to know when visiting the resident’s home, eg dogs, firearms, infectious diseases. Also indicate if risks or hazards are unknown: | | | |

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| 10. Request for variation to funding of residential care | | | |
| Complete this section if funding for the resident’s residential care needs to change.  This may be due to a:   * decrease or increase in the level of residential support required * change in the care provider/facility * change to the bed day rate (eg dual funding arrangement)   need to transition from short term/temporary care into long term care/permanent care. | | | |
| Change request: | Current | Requested |
| Level of residential support: |  |  |
| Price per day: |  |  |
| Provider/facility: |  |  |
| Transition to long term care: |  |  |
| How long will this change be required? | | | |
| What is the rationale for the change in funding? (eg resident has improved mobility since admission, decreased cognition, change in facility etc) | | |

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| 11. Residential care facility contact details and declaration | |
| This section is mandatory and should be completed by the person we will talk to about this resident. | |
| I declare the information provided on this form is, to the best of my knowledge, accurate and complete.  I confirm that a medical assessment has been undertaken by a registered health professional and the results of this are reflected in this form.  I confirm the resident is aware of their financial responsibility if supports are no longer injury related and ACC funded.  I understand ACC may contact me about the resident and this request. | |
| Name: | Role: |
| Organisation: | |
| Phone number: | Email address: |
| Signature: | Date: |

In the collection, use, disclosure, and storage of information, ACC will at all times comply with the obligations of the Privacy Act 2020, the Health Information Privacy Code 2020 and the Official Information Act 1982.