Complete this form to update ACC on a Home and Community Support (HCS) – Return to Independence client’s progress or request a transfer/extension of supports. This form must be completed by a Registered Health Professional.

When you’ve finished, return this form to claimsdocs@acc.co.nz

|  |
| --- |
| 1. Client details |
| Full name:       | Claim number:       |
| Contact number:       | Address:       |

|  |
| --- |
| 2. Supplier details |
| Lead supplier:      Provider (if different):       | Vendor Number:       |
| Contact email:       | Contact email:       |

|  |
| --- |
| 3. ACC details |
| Recovery team:       | ACC recovery team member (if known):       |
| Contact email:       |

|  |
| --- |
| 4. Report details |
| Date of report:       | Date referral received:       |
| Date services commenced:       | Date services completed (if applicable):       |

|  |
| --- |
| 5. Report purpose |
| For all purposes complete section 7 of the form. If you are requesting an additional package or a transfer to HCS – Maximise Independence, then please complete the additional sections as below. |
| [ ]  Progress report | [ ]  Completion report |
| [ ]  Additional package request (complete section 8) | [ ]  Transfer request (complete section 9) |

|  |
| --- |
| 6. Current package details |
| Current funding group: [ ]  Group 1 [ ]  Group 2 [ ]  Group 3 [ ]  Group 4 |
| Total hours delivered in this package:       | Number of packages completed for this claim:       |

|  |
| --- |
| 7. Client progress |
| To what degree has the client achieved their pre-injury independence?[ ]  Exceeded [ ]  Achieved [ ]  Partially Achieved [ ]  Not Achieved |
| If partially achieved or not achieved have been selected, provide reasoning below. You can select an option from the left or include your own barriers to the right.  |
| [ ]  Change in client condition/circumstance outside of supplier/provider control.[ ]  Change in client condition/circumstance due to event/issues arising through provision of services.[ ]  Initial goals or timeframes unrealistic[ ]  Client does not wish to pursue goals/goals changed.[ ]  Change of supplier before date of achievement[ ]  Client attainment of goals slower than expected | Goal 1 Barrier:      Goal 2 Barrier:      Goal 3 Barrier:       |

|  |
| --- |
| 8. Additional package request |
| Please tick one of the following to confirm eligibility for a further package. Requests must be **within 1 month** of current service expiry. |
| [ ]  The current package has exceeded 6 months since it commenced (or will within the next 4 weeks)[ ]  The current package has exceeded 60 hours of care for group 1 or 2[ ]  The current package has exceeded 120 hours of care for group 3 or 4 |
| In the box below, provide a rationale for your request:* indicate specific goals to be achieved.
* state strategies to be used to improve independence.
* state how ongoing care needs are due to the covered injury.

If there is an increase in care needs, please state reason. |
|       |
| Requested additional package start date:       |

|  |
| --- |
| 8. Transfer to HCS – Maximise Independence |
| Please confirm which of the service eligibility criteria for HCS – Maximise Independence have been met: |
| [ ]  The client has received 4 packages on this claim in total.[ ]  The client requires assistance to feed (not including meal preparation).[ ]  The client requires assistance of a support worker to mobilise to the toilet or manage incontinence products several times a day.[ ]  The client will need at least 2 support workers in delivery of most of the attendant care needs of the client for either of the following reasons:* The safety of a support worker who is to deliver the attendant care services AND/OR
* The clinical needs of the client (please elaborate below).

[ ]  The client requires overnight care. [ ]  The client receives HCS - Maximise Independence on another claim. |
| In the box below**,** provide a rationale for transfer. This must include:* What has changed since the Client was initially accepted into HCS - Return to Independence.
* Explain how ongoing cares are due to the covered injury.
* State strategies to be used to improve independence.
 |
|       |
| ACC is likely to request an independent needs assessment. If care hours need to be continued until such as time as an assessment can take place, please outline how many hours per week the client will require:       |
| Attach updated Individual Support Plan (ISP): [ ]  Yes [ ]  No If the request is for an extension to HCSRTI or a transfer to HCSMI you must attach an updated ISP. If you are completing a progress report, attach an updated ISP if goals/circumstances have changed.  |

|  |
| --- |
| 9. Supplier declaration |
| I declare the information provided by me on this form is, to the best of my knowledge, accurate and complete. |
| Name:       |
| Signature:      Note emailed document will be deemed as signed by person named | 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.