Complete this form to request a change in supports for a Home and Community Support - Maximise Independence client. This form **must** be completed by a Registered Health Professional.

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

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

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

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| --- | --- |
| 3. ACC details | |
| Recovery team: | ACC Recovery Team Member (if known): |
| Contact email: | |

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| --- | --- |
| 4. Report details | |
| Purpose of report:  Change current support  Notify ACC of support completion | |
| Date of report: | Date referral received: |
| Date services commenced: | Date services completed (if applicable): |

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| 5. Current supports | |
| Standard hours: | Complex hours: |
| Per:  day  week  fortnight | |

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| --- | --- |
| 6. HCSMI change in Standard or Complex support | |
| Complete this section if you are requesting a change in the service.  Confirm the number of additional hours required. | |
| Standard hours: | Complex hours: |
| Per:  day  week  fortnight | |
| How long is the support required for: \_\_\_\_\_\_\_\_\_ weeks (maximum 52) | |
| Start date: | End date: |
| Provide clinical details and rationale for the requested changes.  ACC may seek an independent assessment and will confirm any changes in writing. | |
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| 7. HCSMI completion report | |
| Complete this section if you are confirming that the service is complete. | |
| Why is the service complete? | |
| Client achieved all outcomes and no longer requires services. | Client has not achieved all outcomes but no longer wishes to receive services. |
| Client has requested a new service provider. | Client has passed away. |
| Other (please outline): | |
| Is there anything else you would like to let us know? eg referrals required into other services | |
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| 8. Declaration and signature | |
| I declare the information provided by me on this form is, to the best of my knowledge, accurate and complete. | |
| Name: | |
| Signature:  Electronic documents will be deemed signed by the 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.