MENTAL HEALTH CARER SUPPORT FUND APPLICATION FORM

CARER SUPPORT FUND AIM AND OBJECTIVES

The aim of the Carer Support Fund (CSF) is to assist carers in their role of caring for a person with a mental illness. The CSF will assist carers by providing financial support to reduce the costs associated with the caring role and maintaining the carer's health and wellbeing.

NOTE: *Carers are defined as a family member, partner or friend whose primary relationship with a person with a mental illness is a supportive, caring relationship.*

ELIGIBLE APPLICANTS

CSF applicants must be carers of a person who is receiving services from a Victorian public mental health service or program. Applications may also benefit the person with the mental illness, provided the carer is the main beneficiary.

INELIGIBLE APPLICANTS

A person employed to care for a patient or consumer is not eligible to apply for this assistance.

CARER APPLICATIONS

- CSF applications from individual carers have a recommended cap of up to $750 per application.
- Applications for carers must not exceed $1,000 in a financial year.
- Carer claims in excess of $750 will be considered only where extenuating circumstances are documented.
- Written information in support of the extenuating circumstances will be required to support the application.
- AMHS staff preparing CSF applications do so on behalf of and in consultation with carers
- AMHS Staff submit the CSF applications to an AMHS CSF approver for approval/decline
- AMHS CSF approvers review the application against CSF eligibility criteria,

When approved:

- AMHS forward the application to Tandem (the Central CSF Administrator) for processing.

The Central CSF Administrator – Tandem will:

- Review and process applications forwarded by AMHS, support AMHS enquiries.

ALL APPLICATIONS ARE APPROVED BY THE AMHS VIA THE AMHS LOCAL APPLICATION PROCESSES

As such - All AMHS have Registered CSF Approvers, led by the AMHS CSF administrator.
Support or advice for the use and application of the CSF should be via the AMHS CSF administrator as a first step.

SUBMITTING AN APPLICATION

Online applications can be accessed via: http://carersupportfund.carersnetwork.org.au/dotnetnuke. If you are not registered for online applications please email your full email signature and contact details to csf@tandemcarers.org.au to be provided with access and login details.

This application form is to be used when the online capacity is unavailable.

After completion, mail, fax or scan and email this application to the Carer Support Fund Administrator at Tandem

- **Fax: 03 8803 5599**
- **Email: csf@tandemcarers.org.au.**
- **Address 1/37 Mollison Street, Abbotsford, 3067**

For Tandem use only

Date application received		Signed
Date of payment		Signed

Before completing, please consider the following:

1. *Has the availability of other sources of funds been considered?*
2. *Do the goods and/or services assist the carer in relation to their caring role and in maintain their health and wellbeing?*
3. *Does the assistance meet an immediate need or avert a potential crisis?*
4. *Are the goods and/or services of reasonable standard and cost?*

Please write a brief description of how this application supports the carer:

If the application is in excess of $750 please write a brief description regarding the extenuating circumstances.

CONSUMER DETAILS

State-wide UR N0. ______________________________ **Date of birth** ______________________________

Gender: M F

CARER DETAILS

Title (Mr, Miss, Mrs, Ms etc) __________

Family Name

First Name

Address

IMPORTANT

The Carer has consented to the application.

The Carer has consented to the release of their name and contact details to Tandem Inc. for the purpose of proces this application.

Signed by carer or AMHS staff completing application. ………………………………………………………

ITEM AND SUPPLIER DETAILS

Item description. **Please note: a separate application is required for each different supplier.**

Amount of funds requested in this application: _$__________________ **incl. GST**

A SUPPLIER MAY INCLUDE AN AREA MENTAL HEALTH SERVICE OR THE CARER REQUIRING REIMBURSEMENT.

Supplier Name

Address

Suburb **Postcode** ______________

ABN ____________________________ *(If applicable)*

Supplier Invoice Number

PAYMENT DETAILS

NOTE: Payment is made only by cheque or EFT

Cheque to be made to: **Supplier** ☐ **Area Mental Health Service** ☐ **Carer** ☐

Cheque to be posted to: **Supplier** ☐ **Area Mental Health Service** ☐ **Carer** ☐

OR

Bank Details for Electronic Funds Transfer

Account Name

BSB: ___ ___ ___ / ___ ___ ___

Account No: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

AREA MENTAL HEALTH SERVICE DETAILS

AMHS Service Name ____________________

Address
Full postal address ____________________

____

Program Type (Please tick) **Adult** ☐ **Aged** ☐ **CAMHS**☐ **Other** ☐

APPLICANT DETAILS
eg. Case Manager, Carer Consultant, Clinician etc

Family Name ____________________

First Name ____________________

Email ____________________

Phone ____________________

Position ____________________ Signature ____________________

Date ____________________

APPROVED BY:

Name ____________________

Signature: ____________________

Date: ____________________

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