Client Referral Form	Bobby Goldsmith Foundation

Please complete all sections of this form for a referral to services at Bobby Goldsmith Foundation. All information recorded on this form will remain confidential. Submitting this referral form does not guarantee eligibility to services. Incomplete applications will not be accepted.

THE FOLLOWING DOCUMENTATION NEED TO BE SUBMITTED

IN ADDITION TO THIS REFERRAL FORM:

☐ *A completed medication form signed by a health care professional stating HIV medication and other HIV related illnesses that require medication*

☐ *A current Centrelink Income Statement and/ or two recent payslips if employed**

☐ *Bank statements for all current accounts from the last two months**

☐ *NDIS Plan and support coordinator details if applying for NDIS*

☐ *Financial details of partner if residing with the applicant**

only required if the applicant is applying for financial assistance

Send this completed form with all supporting documentation to Bobby Goldsmith Foundation:

By Fax: *(02) 9283 8732*

By Email: *bgf@bgf.org.au*

By Post: *PO Box 1444 Strawberry Hills, NSW 2012*

In Person: *Level 3, 111-117 Devonshire Street, Surry Hills NSW 2010 (Attn: Reception)*

Important Information Regarding the Referral and Intake Process

- Once BGF has received this referral application together with ALL the supporting documentation, the applicant will be contacted to arrange an intake appointment. The intake appointment could take up to one hour.
- After the intake appointment, eligibility to access BGF services will be assessed. The applicant will be contacted by BGF within two (2) working days of the appointment to discuss the outcome.
- If at any point during the referral and intake process the applicant wishes to withdraw their application, they are at liberty to do so.
- If the applicant or referrer wishes to discuss any matters relating to this referral or the intake process, please contact Reception at BGF on (02) 9283 8666 or by email at bgf@bgf.org.au

1. **Personal Details** (fields marked with an * are mandatory)

*Surname:	*Given Names:
*Date of Birth:	*Approximate date of HIV diagnosis:

Which of then following best describes your current gender identity

- ☐ Woman
- ☐ Man
- ☐ Non-Binary
- ☐ Something Different

Are you of Aboriginal or Torres Strait Islander origin

- ☐ Yes, Aboriginal
- ☐ Yes, Torres Strait Islander
- ☐ Yes, Aboriginal and Torres Strait Islander
- ☐ No
- ☐ Prefer Not to Say

Which sex were you assigned at birth?

- ☐ Female
- ☐ Male

What is your ethnic or cultural background? (e.g. Greek, Vietnamese, Lebanese,)

- ☐ Anglo-Australian only
- ☐ Other:

Do you consider yourself to be?

- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Queer
- ☐ Straight/Heterosexual
- ☐ Something Different

Do you speak a language other than English?

- ☐ Yes:
- ☐ No:

Do you require an interpreter?

- ☐ Yes:
- ☐ No:

Were you born with a variation of sex characteristics? (This is sometimes called intersex)

- ☐ Yes:
- ☐ No:
- ☐ Prefer not to say

Are you an Australian resident?

- ☐ Yes:
- ☐ No:

2. **Contact Details** (fields below marked with an * are mandatory)

Preferred contact method	☐	Phone	☐	Email	☐	Post	☐	Any
*Phone Number:				Mobile Number:				
*Email:								
*Residential Street Address:								
*Suburb:						*Postcode:		
Mailing Address(if different):								
*Suburb:						*Postcode:		
*I would like my mail de-identified; ☐								

3. **What is your main reason for contacting BGF?**

☐	Casework Support	☐	Case Management	☐	HIV related Medical Financial Assistance
☐	Financial Advocacy	☐	Community Support	☐	No Interest Loan Scheme (NILS)
☐	National Disability Insurance Scheme (NDIS)		☐	Work and Development Order (WDO)	
☐	BGF Self-Development Workshops e.g. Take Control of Your Health or Phoenix				

4. **What is the client's psychosocial history?**

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5. **Are there any risks to report? (health, behaviours, pets)**

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6. Referrer Details

Self-referred? Go to question 7

Referrers Name: ____

Organisation:____

Email:____

Address: ____

Preferred method of contact ☐ Email ☐ Phone ☐ Any

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7. Consent for Referrer (*Please ensure person being referred ticks all boxes below*)

☐ I am aware of the referral being made to BGF

☐ I consent for BGF to gain information from/release information to the referrer (as per section 1)

☐ I am aware that submitting this form does not guarantee eligibility for BGF services

8. Signature of Person Being Referred to BGF

Name:

Signature: ____

Date: _____/_____/________

9. Signature of referrer

Name: ____

Signature: ____

Date: _____/_____/________