Hopewell Services

Agency Request For Respite Funding

Client Name: _____

DOB: _____

Carer Name: _____

Phone:_____

Email: _____

Client Information

Address: _____ Post Code:_____

Country of Birth:_____

Indigenous Status (Required for funding and reporting):

☐ Neither Aboriginal nor Torres Strait Islander

☐ Both Aboriginal and Torres Strait Islander

☐ Torres Strait Islander but not Aboriginal

☐ Aboriginal but not Torres Strait Islander

☐ Not Stated / Unknown

For Overnight Nursing Respite Funding: Email Request to hopewellfamilysupport@wmq.org.au

Clients registered with Gold Coast Supportive and Palliative Care Service are eligible for respite care.

Client Reference Number:_____

Requested By: _____ Date: _____ Contact Number: _____

GCHHS ☐ Branch: Carestaff ☐ Branch:

Anglicare ☐ Branch: Blue Care ☐ Branch:

Ozcare ☐ Branch: **After Hours Phone**:_____

Respite Care Request: **RN** **EN** **AIN** (Please Circle)

Date Required	Hours Required	AM (Hours)	PM (Hours)	Night (Hours)	Saturday (Hours)	Sunday (Hours)	Total hours This week

***Please do not commit to providing respite care until approval has been received from Hopewell

Diagnosis & Prognosis:

Additional Comments or Considerations:

Phase: _____ Rug/ADL:_____ AKPS: _____

Hopewell Office Use Only

Approved By	Signature	Date/Time	RIP Date/Time	Place of Death (Circle)		
				Home	Hospital	RACF