



Children's Contact Service Application Form

Each parent must complete separate application forms. Please complete all pages.

(The term "parent" is interchangeable with significant person in the child's life requiring this service.)

Service Requested:

Supervised Contact

Facilitated Changeover

Details of children to be involved in proposed arrangements

Please circle

First name: _____ Last name: _____ DOB: _____ M/F

First name: _____ Last name: _____ DOB: _____ M/F

First name: _____ Last name: _____ DOB: _____ M/F

Suburb where the child/ren live: _____

Your first name: _____ Last name: _____

Date of birth: _____

My relationship to child/ren: Mother Father Other _____

The child/ren live primarily with me The child/ren live primarily with their other parent

Address: _____

Postcode: _____

Phone: _____ (Landline) _____ (Mobile)

Country of Birth: _____

Other parent's name: _____

Other parent's address: _____

Postcode: _____

Phone: _____ (Landline) _____ (Mobile)

Legal Representation

Do you have a lawyer? Yes No

Your Legal Representative:

Lawyer's name and Firm: _____

Address: _____

_____ Postcode: _____

Phone _____ Fax _____

Other Parent's Legal Representative:

Lawyer's name and Firm: _____

Address: _____

_____ Postcode: _____

Phone _____ Fax _____

Independent Children's Lawyer:

Lawyer's name and Firm: _____

Address: _____

_____ Postcode: _____

Phone _____ Fax _____

Are there current Court Orders or Parenting Plans? Yes No

(Please attach a copy)

Is there a Family Violence Order or Intervention Order in place? Yes No

(Please attach a copy)

Is Child Protection currently involved with your family? Yes No

(Please note that people currently involved with Child Protection are not eligible to use the Children's Contact Service)

Reasons for applying to use Children's Contact Service

FAMILY SUPPORT PROGRAM DATA COLLECTION SYSTEM

CLIENT FORM

The Australian Government provides funding to Bethany under the Family Support Program through the Department of Social Services (DSS) and/or the Attorney-General's Department (AGD).

As part of the services provided to you by Bethany we need to collect some information about you to assist DSS and/or AGD in assessing the Children's Contact Service's effectiveness in providing support. To assist this process, Bethany will enter this information into the FSP Data System. Once your information is entered in the FSP Data System, your first and last name will be replaced with a unique code that will de-identify your information, making it anonymous when displayed to DSS and/or AGD.

DSS and AGD are bound to protect the privacy of individuals under the *Privacy Act 1988* (Commonwealth) and Bethany has signed a legal agreement to comply with the same rules. Your information will not be provided to a third party (outside DSS and AGD) unless required or authorised by law, for example, to protect someone from harm.

In order for you to make a decision about whether you will provide consent, please note:

- the reasons for collecting your information set out above and details about how that information will be used;
- that your information is kept securely and only used by people who need the information;
- that your information will be entered into the FSP Data System;
- that your information will be de-identified when displayed to DSS and/or AGD ;
- that your information will not be identified in any report or publication; and
- that your information will not be further disclosed unless authorised or required by law.

Your involvement in providing this information is completely voluntary.

Acknowledgement and Consent

I acknowledge that I have read and understand the information outlined above.

Yes **No** *(Please circle your response)*

I consent to the collection of my information by Bethany in the attached form and this being shared with Bethany's Coordinated Intake Team, and it being disclosed in a de-identified way to DSS and/or AGD for the purposes outlined in this form.

Yes **No**

I consent to being contacted by Bethany at a later date to participate in follow up, evaluation and/or research purposes.

Yes **No**

I understand that I can withdraw my consent at any time.

Client Name:

Signature: Date:

CLIENT FORM

* First Name: _____

* Last Name: _____

* Date of Birth: __/__/____

* Or your age: _____

* Gender: Male Female GLBTI

* Are you of Aboriginal or Torres Strait Islander origin:

No Torres Strait Islander
 Aboriginal Both

* Country of Birth: _____

If born overseas:

Date of first arrival in Australia: __/__/____

Visa Type:

Humanitarian Family
 Skilled Other

Ancestry: _____

* What is the main language you speak at home:

English Italian
 Arabic Mandarin
 Cantonese Vietnamese
 Greek
 Other: please specify: _____

* Do you have a disability or impairment:

Intellectual / learning
 Psychiatric
 Sensory / Speech
 Physical / Neurological
 No disability
 Other: _____

* Homeless: Yes No

* Household composition:

Single (person living alone)
 Sole parent with dependants (s)
 Couple
 Couple with dependant(s)
 Group (related adults)
 Group (unrelated adults)
 Homeless / No household

* Main source of income:

Nil income
 Employee salary/wages
 Self employed (unincorporated business income)
 Government payments/pensions/allowances
 Other income including superannuation and investments

* Income frequency:

Weekly
 Fortnightly
 Monthly
 Annually

* Approximate gross income: _____
(whole dollars only)

* What is the main purpose that brought you to this service:

Children Legal
 Relationship Violence / Abuse
 Parenting Health/Addictions

Please post form to:

*Bethany Contact Service
16 Ballarat Rd,
Hamlyn Heights, VIC 3215*