**Eligibility Screen - Modified Driving Controls**

See procedure *‘Completing eligibility assessment screening tool’* for instructions on completing this screen

**Client name: Client/file number:**

**Client DOB: Client address:**

**Screen Completed by: Name: Position:**

**Screen Completed with:** q **Client** q **Other:**

 *(name and relationship to client)*

**Confirm diagnosis/relevant recent medical history:**

**Current Equipment Program equipment:**

**Current services received:**

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| --- |
| **1. Does the client live in a residential aged care facility or receive an Aged Care package?** ❑ Yes, refer to procedure q No, continue with screen |
| **2. Is the client a DVA Gold Card Holder or are they eligible for the equipment item through compensation payment or any other source?** ❑ Yes, if person is eligible for the item from DVA, compensation or other funding, screening assessment can be stopped at this point, person ineligible via Equipment Program. q No |
| **3. Does the client currently drive a vehicle with modified driving controls?** Check equipment records. q Yes If records show and client confirms they have modified driving controls through the Equipment Program, record issues with it / reason replacement is needed and cease eligibility assessment. Likely to be eligible. May need clinical review if replacement required to manage change in client function. ❑ NoDetails of who owns it / issues with it: |
| **4. Has the client been assessed by a Driver Trained Occupational Therapist or Driver Assessment Unit? Have they obtained their driver’s license?**  ❑ Yes ❑ No, advise the client that this will need to occur at their own cost, before they can be considered for the provision of modified driving controls. Cease eligibility assessment. |
| **5. Does the client use a manual wheelchair?**Details of use / distances that person / carer can propel client in manual w/chair: |
| **6. What type of transport does the client currently use?** Consider public transport, private transport, taxis, access cabs. Details:  |
| **7. How does the client transfer in and out of a vehicle?** *Consider person’s ability to independently transfer in and out of the vehicle, how they transfer their wheelchair in/out of the vehicle*Details:  |
| **8. Does the client have any help from carers?** (family members or paid carers) *consider whether carer is managing/coping and carer’s health.*Details of hours of carer assistance available and tasks assisted with: |
| 1. **Does the client drive or do they live with someone who is able to drive them to where they need to go?** *Consider relationship of any potential drivers and sustainability/appropriateness of them assisting the person with transport e.g. person’s spouse who does not work may be appropriate while a house mate or someone who works full time may not be appropriate to complete this role. Consider whether carer is managing/coping and carer’s health.*

***If the client can drive*: Can the client transfer in/out of the car and complete the tasks that they need to do when they get to their destination?**Any details/issues/difficulties: |
| **10. How does the client currently get their shopping done/attend medical appointments? Would this change if they had modified driving controls?**Details: |
| **11. Does the client own their own car? How old is the car? How long do they intend to keep the car?**  |
| **12. What other options has the client tried/considered?** (E.g. home delivery of groceries, MoW, any council or community services available. Details of options and why unsuitable: |
| **13. How often would the client use a modified vehicle if they had one?**  |
| **14. Would you or the client like to provide additional information about the need for modified driving controls?** |
| **15. Does the client/carer give consent for the Equipment Program Delegate to talk to other health professionals to provide extra information if needed?** ❑ Yes ❑ NoDetails: |

|  |  |  |
| --- | --- | --- |
| 1 | The client owns the vehicle that they wish to modify and intends to keep the vehicle for the foreseeable future? | Y / N |
| 2 | The client is unable to operate a vehicle using standard controls and modified controls would be needed on an ongoing basis? | Y / N |
| 3 | The client has undergone driver assessment process and has obtained their driver’s license? | Y / N |
| 4 | The client is able to independently transfer in and out of the vehicle and to stow and get out their wheelchair independently as applicable? | Y / N |
| 5 | Once out of the vehicle, the client can safely mobilise/propel their wheelchair the distances required to independently complete tasks of daily living? | Y / N |
| 6 | The vehicle will be driven by the client at least 3 – 4 times per week? | Y / N |

A YES to all sections is **likely** to make the person eligible for modified driving controls. A clinical review may be required if request for replacement is due to deterioration in client’s function. The age and condition of the vehicle and its suitability to have the modifications installed will need to be assessed by the supplier/installer (Equipment Program will only provide vehicle modifications for a client once every 5 years).

Signature of person completing the screening assessment

Print Name: Date completed

**To be completed by the Equipment Program Delegate:**

**Final outcome – Eligible? ❑ Yes ❑ No**

Signed by delegate: Date:

Delegate name: Delegate Position:

**❑ Outcome letter sent to client if not eligible**

Signed: Date: