APPLICATION FORM

AN APPLICATION FORM IS TO BE COMPLETED BY EACH PARENT AND RETURNED PRIOR TO THE COMMENCEMENT OF CONTACT SERVICE.

Please fill in this form and return it by email to **julie@familycontactservice.com.au**

IMPORTANT: Please include your surname in the subject heading of the email.

FAMILY CONTACT SERVICE

PO Box 6646
Point Cook VIC 3030

Mobile: 0459363172
Fax: 03 83539282

julie@familycontactservice.com.au
familycontactservice.com.au

ABN 70 310 635 706

CONTACT DETAILS

Name of Applicant:

Address:

Home Phone:

Mobile:

Home Email:

Work Email:

NAME AND DATE OF BIRTH OF CHILDREN

Child 1:

Date of Birth:

Child 2:

Date of Birth:

Child 3:

Date of Birth:

Child 4:

Date of Birth:

Child 5:

Date of Birth:

Child 6:

Date of Birth:

Relationship to Children:

☐ Father ☐ Mother

☐ Other (please specify)

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EMPLOYMENT STATUS: Please indicate

☐ Full Time ☐ Part Time ☐ Casual ☐ Self Employed
☐ Pensioner/Centrelink ☐ Other

ARE YOU OF ABORIGINAL OR TORRES STRAIGHT ISLANDER ORIGIN?

☐ NO ☐ YES Aboriginal ☐ YES Torres Straight Islander
☐ Prefer not to answer

ETHNICITY AND LANGUAGE OTHER THAN ENGLISH:

Ethnicity:

Language spoken other than English:

Do you speak English? ☐ YES ☐ NO

Interpreter required: ☐ YES ☐ NO

If YES, specify type of interpreter required:

DO YOU HAVE A DISABILITY?

☐ YES ☐ NO

If YES, please describe your disability:

Do you need someone to help you with or be with you for communication activities, self-care or body movement activities?

☐ YES ☐ NO

If YES, please specify:

LEGAL REPRESENTATION

Name of Solicitor:

Name of Law Firm:

Postal Address:

Phone:

Fax Number:

Email:

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OTHER PARENT/CARER INFORMATION

Name of Other Parent/Carer:

Address:

Home Phone:

Mobile:

Email:

Relationship to Children: ☐ Father ☐ Mother

☐ Other (please specify)

IS THE OTHER PARENT/CARER OF ABORIGINAL OR TORRES STRAIGHT ISLANDER ORIGIN?

☐ NO ☐ YES Aboriginal ☐ YES Torres Straight Islander

☐ Prefer not to answer

ETHNICITY AND LANGUAGE OTHER THAN ENGLISH:

Ethnicity:

Language spoken other than English:

Do the other parent/carer speak English? ☐ YES ☐ NO

Interpreter required: ☐ YES ☐ NO

If YES, specify type of interpreter required:

IS THERE A DISABILITY?

☐ YES ☐ NO

If YES, please describe their disability:

OTHER PARENT/CARER'S LEGAL REPRESENTATION

Name of Solicitor:

Name of Law Firm:

Postal Address:

Phone:

Fax Number:

Email:

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HAS THE CHILD/REN BEEN THE SUBJECT OF CHILD PROTECTION INVOLVEMENT BY A STATE CHILD WELFARE AUTHORITY?

(Please provide details of child protection agency involved and reasons why)

☐ YES ☐ NO

If YES, please list in point form reasons for child protection involvement:

IS THERE CURRENT CHILD PROTECTION INVOLVEMENT BY A STATE CHILD WELFARE AUTHORITY?

☐ YES ☐ NO

CHILD PROTECTION PRACTITIONER'S DETAILS:

(Please sign Release of Information Form)

Name:

Phone:

Email:

Postal Address:

CLIENT DECLARATION: ALL COSTS ARE PAYABLE PRIOR TO THE FIRST SCHEDULED SUPERVISED CONTACT OR OTHER SERVICES

I, _____ agree that I will pay costs into Family Contact Service's bank account 48 hours or earlier than the first contact or other service commencing of an amount that is equal to the cost for the first fortnight of the supervised contact or cost of other service provided.

Signature of Client:

Date:

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BANKING DETAILS

Bank: Commonwealth Bank
ACC Name: Family Contact Service
BSB #: 063779
ACC #: 10345745

IMPORTANT: Please specify your surname on the deposit transfer.

- The first scheduled supervised contact may be postponed if the cost is not paid in advance;
- Observation notes will not be available for either party / or lawyers unless account is paid in full;
- Notification of cancellation by a parent/carer of supervised contact 24 hours or less will incur a late cancellation fee of two hours if no medical certificate is provided advising the child is unwell. If no doctor's certificate is provided a two-hour cancellation fee will be charged to the residential parent.
- Please note if Family Contact Service staff spend longer than thirty minutes in making session arrangements an administration fee of $60.00 per hour will be charged and shared between the parents.
- An information session with parents/carers will be requested and organised prior to the first supervised contact or other service arrangement.

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CHILD/REN'S INFORMATION

Number of children to be supervised for Contact: ☐

CHILD 1

Name of CHILD 1:

Date of Birth: Age: Gender: ☐ FEMALE ☐ MALE

IS THE CHILD OF ABORIGINAL OR TORRES STRAIGHT ISLANDER ORIGIN?

☐ NO ☐ YES Aboriginal ☐ YES Torres Straight Islander

Country of Birth:

LANGUAGE OTHER THAN ENGLISH:

Does the child speak a language other than English? ☐ YES ☐ NO

If YES, specify:

Interpreter required: ☐ YES ☐ NO

If YES, specify:

CHILD'S LEGAL REPRESENTATION

Name of Solicitor:

Name of Law Firm:

Postal Address:

Phone:

Fax Number:

Email:

PARENTING ARRANGEMENTS - Please provide the following details:

Are there any interim or final parenting orders? ☐ YES ☐ NO

(Please attach copy of the existing parenting order to your email along with application).

Who does the child live with:

What are your current arrangements for time with the child/ren?

When was the last time you had contact with the child/ren?

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MEDICAL INFORMATION

Does the child take any prescribed medication? ☐ YES ☐ NO

If YES, please specify the type and frequency of medication required:

Will the medication be required during the supervised contact? ☐ YES ☐ NO

What arrangements have been made for the supervised parent to administer this medicine?

Please note that the supervisor is not responsible for administering medication.
Arrangements for medication must be made between the parents before contact occurs and is required to be documented by a legal representative of either parent to Family Contact Service.

CHILD 2

Name of CHILD 1:

Date of Birth: Age: Gender: ☐ FEMALE ☐ MALE

IS THE CHILD OF ABORIGINAL OR TORRES STRAIGHT ISLANDER ORIGIN?

☐ NO ☐ YES Aboriginal ☐ YES Torres Straight Islander

Country of Birth:

LANGUAGE OTHER THAN ENGLISH:

Does the child speak a language other than English? ☐ YES ☐ NO

If YES, specify:

Interpreter required: ☐ YES ☐ NO

If YES, specify:

CHILD'S LEGAL REPRESENTATION

Name of Solicitor:

Name of Law Firm:

Postal Address:

Phone:

Fax Number:

Email:

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PARENTING ARRANGEMENTS - Please provide the following details:

Are there any interim or final parenting orders? ☐ YES ☐ NO

(Please attach copy of the existing parenting order to your email along with application).

Who does the child live with:

What are your current arrangements for time with the child/ren?

When was the last time you had contact with the child/ren?

MEDICAL INFORMATION

Does the child take any prescribed medication? ☐ YES ☐ NO

If YES, please specify the type and frequency of medication required:

Will the medication be required during the supervised contact? ☐ YES ☐ NO

What arrangements have been made for the supervised parent to administer this medicine?

Please note that the supervisor is not responsible for administering medication.
Arrangements for medication must be made between the parents before contact occurs and is required to be documented by a legal representative of either parent to Family Contact Service.

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IMPORTANT:

IF THERE ARE MORE THAN TWO CHILDREN PLEASE ATTACH EXTRA PAGES ANSWERING ABOVE QUESTIONS

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SERVICE REQUIRED

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1 TYPE OF SERVICE REQUIRED

Changeover Arrangements: ☐ YES ☐ NO

Supervised Contact Visits: ☐ YES ☐ NO

2 PLEASE PROVIDE COPIES OF CURRENT COURT ORDERS INCLUDING HANDWRITTEN MINUTES

TYPES OF ORDERS INCLUDE:

- Parenting orders
- Intervention orders
- Children's Court orders
- Corrections orders

3 INDICATE DATE OF WHEN SERVICE IS REQUIRED TO COMMENCE

4 HAVE YOU PREVIOUSLY USED ANY OTHER SUPERVISION/CONTACT AGENCY?

☐ YES ☐ NO

If YES, please provide the following details:

Name of Agency:

Phone:

Fax:

Provide brief reasons for change of agency:

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5 CURRENT AND HISTORICAL HISTORY OF CONCERNS

Please indicate if a child or parent/carer has been at risk of harm due to one or more of the risk factors below:

Family Violence:	☐ YES	☐ NO	☐ NOT KNOWN
Stalking Behaviour:	☐ YES	☐ NO	☐ NOT KNOWN
Mental Health:	☐ YES	☐ NO	☐ NOT KNOWN
Substance Abuse: (Alcohol and/or Drugs)	☐ YES	☐ NO	☐ NOT KNOWN
Access to or Possession of Firearms:	☐ YES	☐ NO	☐ NOT KNOWN
Assault of Family Members:	☐ YES	☐ NO	☐ NOT KNOWN
Criminal Charges/ Convictions:	☐ YES	☐ NO	☐ NOT KNOWN
Intervention Orders:	☐ YES	☐ NO	☐ NOT KNOWN
Breached Court Orders:	☐ YES	☐ NO	☐ NOT KNOWN

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE, PLEASE PROVIDE FURTHER DETAILS

Please include: FACTS, INCIDENT, DATES, PERSONS INVOLVED and if the concern was reported to an external authority (police, child welfare authority):

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! PLEASE NOTE THAT YOUR PERSONAL INFORMATION IS PROTECTED BY LAW

Family Contact Service
Owner: Julie Robinson
Mobile: 0459 363 172
Email: julie@familycontactservice.com.au
Website: familycontactservice.com.au
ABN: 70 310 635 706

RECORDING AGREEMENT

I, _____ agree to NOT record/film/publish using CCTV cameras or through any other means/device while any Family Contact Service employee is supervising time with my child/ren including at any other location that supervision may occur or during handover of my children. I understand that during phone conversations with a Family Contact Service employee I am NOT permitted to record phone conversations. In the event this agreement is breached, Family Contact Service will cease service provision.

I agreed to all terms and conditions of the Family Contact Service as signed and understand that service provision is conditional on the terms and conditions set out in the service agreement.

Client Name:	
Signature of Client:	
Date of Signature:	
Signature of Witness:	
Date of Signature:	

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TERMS AND CONDITIONS

I, _____ accept the terms and conditions of this service as set out and discussed during the initial intake session with Family Contact Service.

I understand that the contact service is conditioned on acceptance of and compliance with these terms and will be discontinued should I fail to abide with these terms.

Signature:	
Date:	

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