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2 April 2019

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RE Official information request CDHB 10014 and WCDHB 9266

I refer to your email dated 10 January 2019, and subsequently updated on 14 January 2019, requesting the following information under the Official Information Act from Canterbury DHB and West Coast DHB regarding:

A link to or copy (if the DHB has them) of:

- a) **your DHB's current core policy document on facilitating education access for inpatient and outpatient children and young clients (including tertiary age) and/or**

The Canterbury DHB provides access to the Health School for all children who are inpatients, including children from other regions such as the West Coast. You will find details on the provision of this service on the following website:

<https://www.education.govt.nz/school/student-support/special-education/regional-health-schools-for-children-who-cant-attend-school-because-they-are-unwell/>

I also attach as **Appendix 1**, the Back to School after a Head Injury Canterbury DHB leaflet given to parents and caregivers.

- b) **your DHB's current core policy document on the transition and monitoring of transition from paediatric to adult services. I am aware that at least one DHB has a formal transition process and joint management document for each patient.**
- c) **your DHB's current core policy document on transitions and/or co-management between**
- a) genetic and paediatric services
 - b) paediatric and other specialist services and
 - c) genetic and adult services.

Hopefully these are already documented and my thanks to those who have done key work in these areas. Please also: advise me if you do not have a written policy on any/each of the above, and if these situations are covered in a general DHB policy, and please send a link/copy of these policies.

While we don't have an official policy as such, we do have the following:

The Canterbury DHB has a draft "Transition Pack" with a framework to start having discussions from age 12 yrs. The framework ensures that all young adults have all the information they need by their 16th Birthday. By this age we have usually made any ongoing appointments with either their GP or adult services and have supported them through attending these, ordering prescriptions etc.

This pack is being audited at present and we will make it an official pathway once the audit data is back and any changes needed have been made. We know from the audit so far that this pack works well for most young adults but is not supportive enough for those with complex medical needs. A report is being written currently to make recommendations for this population to provide a more supported transition. The report will be available within the next three months.

I attach as **Appendix 2**, seven transition documents. The first four documents are the standard pack and the other three documents are added if needed. The draft watermarks will not come off until we have completed the audit.

Appendix 2:

Standard pack of four documents:

1. Child-Health-Transition-Cover
2. CH-Transition-Tell-Me-the-Facts
3. Transition-Framework
4. Transfer-to-Adult-Services-Progress

Documents added if needed:

5. CH-Transition-Teenagers-on-Enteral-Feeding
6. Transition-Teenagers-with-Special-Needs
7. Transition Information for carers - neurodevelopmental

Diabetes and Cystic Fibrosis Children probably have the clearest pathways of transition. Transition is also on the Canterbury Clinical Network (CCN) work plan.

Adult services receive transition patients in Oncology, diabetes. Cystic fibrosis, enteral feeding, inflammatory bowel and other GI diseases, complex congenital heart disease.

West Coast DHB:

The West Coast DHB has spoken to their Paediatric Department. They have confirmed there are no specific West Coast policies. Since the service is driven by Canterbury DHB in the Transalpine model the West Coast DHB service would follow the same policies as Canterbury DHB.

I trust that this satisfies your interest in this matter.

Please note that this response, or an edited version of this response, may be published on the Canterbury DHB and West Coast DHB website after your receipt of this response.

Yours sincerely



Carolyn Gullery
Executive Director
Planning, Funding & Decision Support



Back to School after a Head Injury

Parent/Caregiver Information—Paediatric Occupational Therapy



Children and head Injury

For a time after an injury to the head, some children experience concussion.

They may lose consciousness and/or experience other symptoms like headaches, dizziness and nausea.

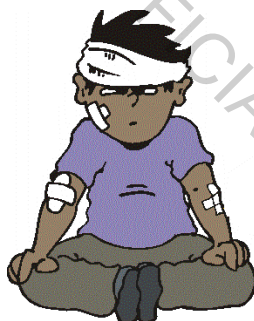
Concussion occurs when the brain has been injured. As the brain recovers this can disturb children's normal physical, emotional and behavioural patterns and also cognitive (thinking).

Most children will recover from concussion within two weeks. Some children however will experience symptoms for weeks or months after the injury.

All head injuries are different!!

Children will experience and recover from head injuries differently.

This pamphlet contains information about returning to school and some of the possible symptoms children experience after a head injury.



Physical symptoms

- Headaches
- Nausea
- Double/Blurred vision
- Dizziness
- Fatigue
- Speech changes
- Clumsiness
- Changes in eating /sleeping patterns
- Seizures
- Blank looks

Behavioural symptoms

- Mood changes
- Personality changes
- Frustration
- Restlessness
- Difficulty interacting with others
- Lack of initiative

Cognitive symptoms

- Decreased concentration
- Memory difficulties
- Difficulty staying on task

Returning to school

When physical symptoms have cleared children may be ready to return to school. School should be commenced on a part-time basis initially (eg. half days).

Classrooms are very busy environments!

There is a lot to see, hear and do. This can be challenging for children while they are recovering from concussion.

While symptomatic children need to limit over-exertion of daily living activities, physical and cognitive (thinking) stressors eg: School, text messaging, computer and play station games.

You may notice children will have an increase in symptoms they experience at some point during the day – this is the brain's way of saying **"I need a rest!"** It is important to make a plan for children to return home from school or at least find a quiet place if/when this happens.

When both teacher and parent are satisfied that the child is coping, time at school can be increased. It should be anticipated that children should be able to fully attend within two-four weeks after the injury.

A few children will take longer to recover. It is beneficial to get some advice from the hospital in this case.



Physical activity

After a head injury, children are required to avoid activity with a high potential for further injury to the head for **6 weeks** (or longer if symptoms have not resolved).

This includes activities such as Physical Education, contact sport and other vigorous activity.

It is important to avoid further head injury as cumulative head injuries can lead to long term damage

If you have any concerns or want more information contact



**Occupational Therapy Services
Christchurch Hospital
Private Bag 4710
Christchurch
New Zealand**

**☎ 64 (03) 364 0700
Fax 64 (03) 364 0085**

Reference: Brain Injury Association NZ : *Understanding brain injury*



For more information about: - your health and medication, go to www.healthinfo.org.nz
- hospital and specialist services, go to www.cdhb.health.nz





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Transition: Getting ready to move on to the Adult Service

THIS INFORMATION PACK EXPLAINS A LITTLE ABOUT THE TRANSITION PROCESS AND WHAT IT WILL MEAN FOR YOU

Department of Paediatrics
CHRISTCHURCH HOSPITAL
CANTERBURY DISTRICT HEALTH BOARD

Ref.238374

Child Health Transition

Transition—Tell Me the Facts



What is transition?

In healthcare, we use the word 'transition' to describe the gradual process of planning, preparing and moving on from the Child Health Team to the Adult Team. Your Adult Team may be within the hospital or in Primary Care or a combination of both. Transition gives everyone time to talk about issues related to this exciting but also challenging time of becoming a young person and to make sure you are ready to make the move.

We usually start talking about transition when you start secondary school. The exact timing of the move from children's to adult service varies from person to person. Our aim is that most young people have moved on to their adult team by their 16th birthday.

Why do I need to move on?

As you grow into a young adult, an adult service will be the best place for you to get the care that is right for your needs. The staff in children's services are expert in caring for babies, children and teenagers and the staff in adult services are the experts in caring for young adults, adults and older people. By the time you are at the end of the transition process, you may feel that you have grown out of the children's services and be glad to move on to a more grown up setting.

The thought of moving to a new team and leaving the staff that you have got to know over the years can be difficult. But we know from experience that it is a good idea to think of this change as a sign that you are growing up and moving on with your life. You might have felt the same way when you moved from primary to secondary school. Once you get used to the adult team you should settle into your new routine and get to know the staff there.

How do I get to meet the adult team

An appointment will be arranged with the adult team prior to you leaving Child Health so that you can meet key members of the adult team. You will receive information about the adult service, contact details for the staff there, how the service is organised and how the adult service differs from the Child Health service. We will show you a framework or map of transition which allows you to learn all of these different parts over 3-4 years rather than all at once.

We will work with you and your family to go through this process and will give you plenty of time to adjust to these changes. We will keep checking in with you and your family to see what else you need to achieve transition.

How do I get ready to move on to the adult service?

We know that approaching a move to adult care can be a scary time which is why we do this slowly so that you get used to each step before we move to the next step.

Your parents have been really important in looking after your health and will be able to give you lots of helpful advice. They will have plenty of experience of things like taking you to the hospital, making appointments, asking questions and making sure you get your medicines and treatments. It is a good idea for you and your parents to talk about how you can start to take on more responsibility in looking after your health. While you are preparing to move on, your parents will still be involved in your health care and still have an important role. This is why we try to have

transition completed by your 16th year so that your first few years in the adult service are supported by your parents.

Young people in adult services are generally seen as being independent. We will help you gain the skills necessary to feel comfortable in the Adult Health service. It will be helpful for you to practise doing the following things to help prepare:

- Learn about your diagnosis and treatment
- Learn the names of your medication, why you need them, how much to take
- Learn how to get more supplies of your medicine
- Start making your own appointments when you need a review
- Keep important phone numbers and appointment dates in your mobile phone
- See your doctor or nurse on your own for at least part of your clinic appointment

You will notice all of these tasks in the transition framework. You will also notice that we give you lots of time to achieve each of these things and we work with you and your parents while you learn these skills.

If you have any questions or concerns about transition, please talk to your nurse or consultant. We are working with you to make this as easy as possible. In this pack you will find more information that will be helpful to you as you go through the transition process.

For more information about: - your health and medication, go to www.healthinfo.org.nz
- hospital and specialist services, go to www.cdhb.health.nz

Transition Framework – Generic

**GETTING
READY**

12-13 yrs

- I know my condition
- I know my medications - their name, what they do and when to take them
- I know about my supplies and equipment

**STARTING
TRANSITION**

14-15 yrs

- I know my Adult team/Primary Care Team (GP)
- I know when I will be seen in adult clinic or by GP
- I know what my GP can do for me
- I know what will happen if I need to be admitted to hospital
- I am responsible for my own medication at home

**TRANSITION
COMPLETED**

15-16yrs

- I have my transition plan
- I know what to do if I become unwell
- I have attended my first adult clinic appointment/GP appointment
- I know how to order my medication and have done this successfully
- I know how to order supplies or equipment and have done this successfully

Transfer to Adult Services Progress Document

Name: NHI: Date initiated:/...../..... Date completed:/...../.....

ALLERGIES:

DIAGNOSES/PROBLEMS	
1.	
2.	
3.	
4.	
5.	
6.	

Paediatric Service	Contact (name/number)	Date Referred	Receiving Adult Service	Adult Service Contact (name/number)	Transfer Status		
					To Initiate	In Process	Complete (seen by team member at adult service)
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							

Information for Teenagers on Enteral Feeding



This information sheet is designed to answer your questions about how transition to adult services will impact on your enteral feeding order and supplies. We have outlined the information most commonly requested but please discuss this with your Child Health team prior to moving to Adult Services.

How do I order supplies in the adult service?

You will be given a phone number for the Supply Department at Christchurch Hospital. Your teenager will have an ongoing supply order which has been set up by the adult dietitian. You will, however, need to phone the Supply Department to let them know you need more supplies. Please phone at least two weeks prior to running out of supplies. All supplies will be delivered to your home. You can choose to get the supplies delivered either monthly or three monthly.

Who do I contact if I have any problems or queries?

Your teenager will be referred to a dietitian and their name and contact number will be put on the 'transition progress document' which you have been given in your transition pack. You can contact this person with any queries that are not related to the pump.

If you have questions or concerns about your pump you can contact the company rep who will be able to help you. We will again put their name and contact details on the 'transition progress document' which you have in your transition pack. The rep for the company is a very knowledgeable and helpful person and they expect to answer questions from parents so do not hesitate to phone them if you have a problem.

As you can see there is an excellent system to ensure that you get the supplies that you need delivered to your home. This hopefully makes it easier for you to get what you need with a minimum of input from you. We will ensure that you have the contact names and numbers of the dietitian, Supply Department and rep for the pump you use. We will also allow plenty of time to trial this system with the support of the Child Health Team to ensure the process is running smoothly prior to the final transfer to the adult team/GP.

If there is anything else you need please just ask.

For more information about: - your health and medication, go to www.healthinfo.org.nz
- hospital and specialist services, go to www.cdhb.health.nz

Child Health Transition

Information for Parents/Caregivers of Teenagers with Special Needs



Your teenager has been growing through childhood with the diagnosis of a chronic health condition. We recognise along with you, that they are becoming an adult and your role as a parent/caregiver regarding their health needs will change. Our aim is for your transition to adult health care to be a gradual and an evolving process which will be completed by age 16.

A number of children in our service have varying degrees of special needs care. Many young adults are unable to learn to take control of their own health. They will continue to rely on parents/caregivers and adult health care professionals to help them.

Transition of care for you and your teenager is designed to explore what needs you have and how we can help you and your teenager adapt to the changes in transition. The transition process follows a logical journey but the support we provide for you will depend on the needs of your family and your teenager.

We recognise an advanced plan of care is required to facilitate the needs of your family through transition to adult services. It is important your access to health care options is continued so that your teenager can maximise their living skills and independence. The following checklist will aid in supporting our partnership with you to ensure your teenager is transitioned to adult specialist and/or primary care (GP) with the supports they need.

- ☐ I know my teenager's diagnosis and what their medications are for.
- ☐ My teenager is informed of their condition at their level of understanding.
- ☐ I have a copy of the transition plan and have discussed this with the paediatric team.
- ☐ The adult/GP team have a copy of the transition plan and they agree with this.
- ☐ I have met the adult/GP team and have had my transition questions answered.
- ☐ I know how to order prescriptions and any supplies needed under adult/GP care.
- ☐ I have had the opportunity to discuss eligible benefits, respite care, etc.

For more information about: - your health and medication, go to www.healthinfo.org.nz
- hospital and specialist services, go to www.cdhb.health.nz



Transition – intellectual disability

Information on transition for parents/carers of a young person with an intellectual or developmental disability

Transition is a process of planning, preparing and moving from a paediatric to an adult health care service. It usually happens during a time of many other changes for your young person, like leaving school, legally becoming an adult, and changing social benefit categories. Preparing for transition involves preparing you and your young person with the knowledge to navigate this process. All decisions should be centered on your young person, what is in their best interest and their right to live a full life, e.g. with good health care and participation in society, while also respecting your role as carer.

Transition ideally is a gradual process and starting early will give you the time to prepare. Discussing transition with your healthcare teams can start when your young person is around the age of 14. This information sheet provides guidance through some of the common practical issues. Many of the services mentioned are based in New South Wales, however most information is relevant to all of Australia.

Please visit our two websites for transition tips and resources:

- Trapeze
Visit: trapeze.org.au
- Agency for Clinical Innovation (ACI)
Transition Care Network
Visit: aci.health.nsw.gov.au/networks/transition-care

Finding support

As a parent/carer of a young person with an intellectual or developmental disability, knowing where you can find support can be useful. You are not alone and it is healthy to turn to others for additional support.

People or organisations that may be helpful:

- Family and friends
- Your general practitioner (GP) or your young person's medical, nursing and healthcare team members
- Support workers or social workers
- Psychologists or counsellors – ask your GP or child's health or medical team for a referral
- Carer support and advocacy
 - Carers NSW
Call: 1800 242 636
Visit: carersnsw.org.au
 - Carer Gateway
Call: 1800 422 737
Visit: carergateway.gov.au
 - Family Advocacy
Call: (02) 9869 0866
Visit: family-advocacy.com
 - Side by Side Advocacy
Call: (02) 9808 5500
Visit: sidebyside.org.au
 - Young Carers NSW
Visit: youngcarersnsw.org.au
- Community support organisations
 - IDEAS (Information on Disability Education and Awareness Services)
Call: 1800 029 904
Visit: ideas.org.au



- HSNet is a website that lists services for ageing, disability, community, welfare and justice.
Visit: hsnet.nsw.gov.au
- The Council for Intellectual Disability
Visit: nsw.cid.org.au
- Ability Links
Visit: abilitylinksnsw.org.au
- Intellectual Disability Rights Service
Visit: idrs.org.au
- Adolescent transition clinics in children's or adult hospitals
 - Trapeze
Call: (02) 9382 5457
Visit: trapeze.org.au
 - ACI Transition Care Coordinators
Visit: aci.health.nsw.gov.au
 - Northern NSW area
Call: (02) 4925 7866
 - Western NSW area
Call: (02) 9845 7787
 - South Eastern NSW area
(including Sydney Metro)
Call: (02) 9382 5455
- National Disability Insurance Scheme (NDIS)
Call: 1800 800 110
Visit: ndis.gov.au

Taking care of yourself

Caring for a young person with an intellectual or developmental disability is a full-time job and sometimes it is easy to put your own needs aside. This can have an impact on your wellbeing and may even affect your ability to care and support your young person in the way you would like.

Some tips include:

- Eat healthily and regularly
- Exercise
- Sleep
- Negotiate sharing roles at home

- Talk to others about your situation
- Set aside time to spend with individual members of your family
- Ask for help when you need it, e.g. from family, friends or your GP
- Accept support from others
- Take time out for yourself to relax
- Do some activities, not necessarily related to your role as carer
- Work in a paid job
- Know your hospital resources, community resources and support groups

The importance of a (GP) for your young person

- It is important to have a good GP close to home.
- Check whether your GP is able to conduct a home visit if needed.
- Your GP should be your first point of call if your young person is unwell.
- Your GP will become the central person in your young person's health care and will usually be the coordinator and referrer to any specialists required.
- Your GP can perform an annual health check (health assessment for people with an intellectual disability) that helps identify and manage your young person's health needs.
- It is often advisable to ask for a longer appointment to enable your GP sufficient time to examine and discuss.
- Ask your GP to write a Chronic Disease Management Plan as this helps to make treatment goals for the next 12 months and provides Medicare funding for allied health services. A Mental Health Plan can open funding for psychological services
- The National Home Doctor Service provides after Hours GP Home Visits Bulk Billed.
Call: 137425 (13SICK)
Visit: homedoctor.com.au



Before leaving paediatrics

- From around the age of 14, talk with your paediatric teams about transition.
- From around the age of 16, ask your paediatric team or specialists who they recommend your young person should see in the adult health care setting.
- Request a summary of care and referral to adult services.
- Request copies of any relevant reports and imaging on DVD to provide to the adult health team.
- The children's hospitals provide medical and allied health (e.g. physiotherapy, occupational therapy) care that may not be available from adult hospitals. You can increase your young person's care options by seeing health care professionals in their private practice. Talk about this with your team. Organisations like Medicare, private health insurance, NDIS and Lifetime Care and Support might be able to provide financial support.
- Think about any special medication or equipment that is organised through the children's hospital that will require planning for its continued use.
- Talk with your paediatric team about how to manage emergency situations during the time between the last children's health appointment and the first adult appointment. An Emergency Management Plan may be useful.

Trapeze and the ACI Transition Care Coordinators are available to assist you through the transition process.

Carer and patient experience

The care provided in an adult hospital may be different to what was provided in paediatric care. For example, staying overnight with your young person at the adult hospital may have to be negotiated with the Nursing Unit Manager. This can be difficult for carers and young people, especially if your young person has complex behaviours and needs which respond to particular care or treatments. Contact the designated Carer Representative or Patient Friend at your adult hospital so they advocate with you and negotiate your young person's needs. Remember that your young person has a right to appropriate health care. There are resources developed to support the communication with health professionals of what is relevant and appropriate for your young person to help in their care.

- Top 5
Visit: bit.ly/2hmlJUL
- Admission2Discharge together
Visit: a2d.healthcare

Medication

Most medications used in Australia are subsidised through the Pharmaceutical Benefits Scheme (PBS), where you will need to have a Medicare card. A Health Care Card can further lower the cost of medication for your young person. Once your medication costs in a calendar year pass a certain threshold, you and your family may be eligible for the PBS safety net. Visit: bit.ly/2wo4Fk4 for more information.

For medications that are not subsidised, you will need to pay privately or you can look into whether they can be covered through other special schemes.

If you obtain special medication through the children's hospital pharmacy, check whether the adult hospital can continue to provide them. If in doubt, speak to the Head of Pharmacy at the children's hospital.



Equipment/resources

If your young person uses equipment such as a wheelchair, standing frame, walking frame, shower chair, suction machine, air mattress, pump, humidifier, oxygen tank etc., check who the equipment belongs to. Sometimes the equipment may be on loan and will have to be returned when the young person transitions to the adult care setting. If your young person uses other resources such as feeding tubes, connections, special feeds, or formula, you will need to find out who supplies the resources and whether they will continue to supply them, or if a new referral and prescription will be required.

If you require equipment or resources, the specialist will help you apply for it or direct you to the appropriate people to help you.

Enable NSW provides equipment and services to people in NSW with chronic health conditions or disability to assist them with mobility, communication and self-care. Enable NSW is a Registered Provider to the NDIS.

Call: 1800 362 253

Visit: enable.health.nsw.gov.au

Legal matters

An enduring guardian is someone who can be appointed to make lifestyle, health and medical decisions for your young person when he/she is not capable of doing this independently. Decisions can also be made about where your young person lives, what services are provided to his/her home and what medical and dental treatment he/she receives.

- Law Access is a good starting point for finding out information about the law and legal issues. They can provide legal advice over the phone and link into relevant services.

Call: 1300 888 529

Visit: lawaccess.nsw.gov.au

- The Council for Intellectual Disability works with and for all people with intellectual disability to advocate for their rights and make life better in all aspects where possible.

Call: 1800 424 065

Visit: nswcid.org.au

- Planning Ahead Tools is a NSW government website with information about organising a will, power of attorney, enduring guardianship or advance care planning.

Visit: planningaheadtools.com.au

Other legal resources include:

- NSW Trustee and Guardian

Call: 1300 364 103

Visit: tag.nsw.gov.au

- NSW Public Guardian

Visit: publicguardian.justice.nsw.gov.au

- Legal Aid NSW

Visit: legalaid.nsw.gov.au

- Aboriginal Legal Services NSW

Visit: alsnswact.org.au

- Intellectual Disability Rights

Visit: idrs.org.au



Financial matters

Many people with a disability can be supported to manage their own money. A family member can become a joint signatory on a bank account. Other avenues include becoming a payment nominee for their Centrelink entitlement, appointment of Power of Attorney or having one appointed from the NSW Trustee and Guardianship to look after their financial affairs.

If your young person is earning an income, including payments from Centrelink, they may be required to complete an annual tax return. In the case of an appointed guardian, this person would need to be the registered contact with the Australian Taxation Office. Often parents take on this role. People with disability may be eligible for tax and superannuation concessions and exemptions. For further information, contact the Australian Tax Office. Call: 13 28 65.

Visit: ato.gov.au/individuals/people-with-disability

MyGov

MyGov is a website that provides access to a range of online services in one place. Some of the These services include:

- Medicare
- Child Support Australia
- Australian Tax Office
- Centrelink
- Australian JobSearch
- MyHealth Record
- National Disability Insurance Scheme

Call: 132 307

Visit: my.gov.au

Australian Taxation Office

If your young person secures employment or receives other forms of income (including Centrelink payments), he/she will need to open a bank account and apply for a Tax File Number (TFN). The diagram on page 7 explains the process of applying for a Tax File Number.

Proof of eligibility

If you are applying on behalf of the TFN recipient, you must provide a current document that proves your authority to act on their behalf (proof of eligibility document). The proof of eligibility document should include both the TFN recipient's name as well as your name. Acceptable proof of eligibility documents are:

- Australian birth certificate
- Medicare card
- Foreign birth certificate
- Letter of Attorney
- Power of Attorney
- Proof of parentage/guardianship documents

Department of Human Services (Centrelink)

Centrelink offers a range of payments including the Health Care Card to subsidise medication under the PBS.

Payment Finder can help determine what your young person is eligible for.

Call: 132 717 (Disabilities and Carers Line)

Call: 132 490 (Youth and Students Line)

Call: 131 202 (Multilingual support)

Visit: bit.ly/2wnVrEv



Enrolling to vote

It is compulsory in Australia for all Australian citizens over 18 years old to enrol and vote in elections (federal, state and local). If your young person cannot understand the voting process, there are two options:

1. Temporary option. From 16 years old, you can notify the Australian Electoral Commission by telephone and ask for your young person to be placed on their exemption list which will last for five years before needing renewal.
2. Permanent option. From 18 years old, you can enrol your young person with the Australian Electoral Commission. Once enrolled, there is an "Objection claim that an elector should not be enrolled" form that requires a medical practitioner's verification and if successful, this permanently removes your young person from the electoral roll.

Call: 132 326

Visit: bit.ly/2vvsKT5

Post-school options

Leaving school is a significant transition point in the life of a young person with a disability. Your child's school will normally provide you with lots of information and will support you through the post-school option application process. There are a number of useful resources available for you to help navigate this process and attending post-school options is a great way to get the latest information and learn about what services are available.

- National Disability Coordination Officer Program
Visit: education.gov.au/national-disability-coordination-officer-programme
- TAFE NSW
Visit: tafensw.edu.au
- Universities: Each university will have their own Disability Support Service
- National Disability Insurance Scheme (NDIS) have School Leaver Employment Supports
Call: 1800 800 110
Visit: ndis.gov.au/people-disability/sles
- Disabled Australian Apprentice Wage Support Program. This is a government payment that assists employers of eligible Australian apprentices who have disabilities. For young people, this provides support with tutorial, interpreter and mentor services.
Call: 132 717
Visit: australianapprenticeships.gov.au/programs/support-australian-apprentices-disability



Applying for a Tax File Number (TFN) and becoming your child's registered contact for taxation purposes

Get some documents together

Doctor's letter

Ask your child's doctor to write a letter stating your child does not have the capacity to manage their own tax affairs

Your letter

Write a letter to the ATO requesting that you be your child's registered contact

Identification

Gather some identification for:
Yourself
Your child
Your relationship
(to your child)

Apply for a Tax File Number

Access TFN form through Centrelink

A TFN application form can be provided at your local Centrelink office (on behalf of your child) while applying for a new Centrelink payment for your child.

Apply through the ATO

Fill out a TFN Application Form on behalf of your child. (You can get this form from any ATO Office or off the ATO's website.)

Tax File Number received

Visit your local Australian Taxation Office with:

- Doctor's letter
- Your letter
- Identification
- Your child's TFN

Make sure you explain to the Taxation Office that you want to be registered as your child's "registered contact."

Visit your local Australian Taxation Office with:

- The completed TFN Application Form
- Doctor's letter
- Your letter
- Identification

Make sure you explain to the Taxation Office that you want to be registered as your child's "registered contact."

You should now have the authority to take care of all your child's taxation needs, including signing taxation forms on their behalf.