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| **About the NDIS Participant** |
| **NDIS Number** |  | **Request Date** |  |
| **Preferred Title** | [ ]  **Miss** | [ ]  **Master** | [ ]  **Ms** | [ ]  **Mrs** | [ ]  **Mr** | [ ]  **Other** |
| **First Name** |  | **Surname** |  |
| **Telephone** |  | **Mobile** |  |
| **Email** |  | **Date of Birth** |  |
| **Address** |  |
|  |
| **Disability Information** | [ ]  **Psychosocial**[ ]  **Autism** | [ ]  **Intellectual**[ ]  **Physical** | [ ]  **Mental Health**[ ]  **Other - Specify** |
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| **Preferred Worker** | [ ]  **Male** | [ ]  **Female** | [ ]  **No Preference** |
| **Indigenous Status** | [ ]  **Aboriginal** | [ ]  **Torres Strait Islander** | [ ]  **Both** | [ ]  **Neither** |
| **Interpreter Required** | [ ]  **Yes** | [ ]  **No** | **Preferred Language** |  |
| **Cultural Considerations** |  |
| **Additional Information regarding how best to support Participant** |  |
| **Participant’s Nominee Contact (Next of Kin)** |
| **Name** |  | **Relationship to Client** |  |
| **Address** |  |
| **Telephone** |  | **Mobile** |  |
| **Email** |  | **Alternative Contact** |  |
| **About the NDIS Plan** |
| **Start Date** |  | **End Date** |  |
| **Plan Included** | [ ]  **Yes** | [ ]  **No (Please specify goals if not plan provided** |
|  |
| **Billing Details** | [ ]  **NDIA** | [ ]  **Third Party** | [ ]  **Self-Managed** |
| **Plan Manager or Self-Management Details****(Name, Contact, Email)** |  |
| **Who is Completing this Request for Services** |
| **Agency Name** |  |
| **Contact Person** |  | **Contact No.** |  |
| **Email** |  | **Mobile** |  |

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| **Community Inclusion** | [ ]  Disability & Psychosocial Support | [ ]  Safe & Sound Protocol Program |
| **NDIS Support Item Number** **Start & Finish Date of Service** | **Cost per hour** | **How many hours per service** | **Transport Required? Y/N** | **How many km are required for travel per supports?** | **Is transport to be self-funded by participant or the NDIS Plan to be used?** | **Service Information** (Times, Days & other Comments) | **Are these times & days flexible? Y/N Suggestions?** |
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| **Number of Weeks of Service for the Plan Period?** | [ ]  50 weeks (No Service in the weeks of Christmas & New Years) | [ ]  52 Weeks (All Year) | [ ]  Other | [ ]  Until end of Plan |
| **If the support falls on Public Holiday, would you still like to be supported?** (Please Note: This will be charged at the public Holiday Rates for the particular day) | [ ]  Yes[ ]  No | **What is the estimated date you would like service to commence?** (Please Note: Commencement at SASS is due to staff availability and our intake process) |  |
| **Disability Support Needs** |
| [ ]  Personal Care | [ ]  Transfers (Manual Handling) | [ ]  Community Access | [ ]  Cleaning | [ ]  Gardening | [ ]  Cooking | [ ]  PEG Feed/Medication | [ ]  Medication |
| **Have you provided a Health Summary (Discharge Summary) with this request?** |
| [ ]  Yes (This is required for prioritisation) | GP Name |  | GP Clinic |  |
| [ ]  No (Please provide consent & GP details so information can be obtained) | Phone |  | Consent | [ ]  Yes | [ ]  No |
| **Activity Type** | **NDIS Support Item No.** | **Cost** | **Service Information** (Times, Days & purpose of request e.g. functional assessment, SDA, Swallowing assessment, meal plans etc) |
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| **For initial assessment SASS requires a minimum allocation of 2 (two) hours per shift** Personal Care, transfers/Manual Handling is 2 hours*Please speak with our Director or Program Managers if you have any concerns about minimum SASS hours on (phone number or Phone Number)* |