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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** |  | | | | | | | |
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| **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)* | | | | | | | | | | | | | | | | | | | |