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| **About the NDIS Participant** | | | | | | | | |
| NDIS Number |  | | | | Request Date | |  | |
| First Name |  | | | | Middle Name | |  | |
| Surname |  | | | | Preferred Name | |  | |
| Phone Number |  | | | | Mobile Number | |  | |
| Email Address |  | | | | Date of Birth | |  | |
| Address |  | | | | | | | |
|  | | | | | | | | |
| **Disability Type** | ☐ Psychosocial  ☐ Autism | | | | ☐ Intellectual  ☐ Physical | | ☐ Mental Health  ☐ Other - Specify | |
|  | | | | | | | |
| **Secondary Condition** | ☐ Psychosocial  ☐ Autism | | | | ☐ Intellectual  ☐ Physical | | ☐ Mental Health  ☐ Other - Specify | |
| **Preferred Worker** |  | | | | | | | |
| **Indigenous Status** | ☐ Aboriginal | | | ☐ Torres Strait Islander | | ☐ Both | | ☐ Neither |
| **Communication** | ☐ Verbal | | | ☐ Gestures | | ☐ Communication Aids | | ☐ Sign Language |
| **My preferred method of contact** | ☐ Phone | | | ☐ Face to Face | | ☐ Email | | ☐ SMS |
| **Interpreter Required** | ☐ Yes | ☐ No | | | Preferred Language | |  | |
| **Cultural Considerations** |  | | | | | | | |
| **Who l live with** | ☐ I live alone  ☐ SRS | | | | ☐ I live with family  ☐ SDA | | ☐ Aged Care  ☐ Other - Specify | |
|  | | | | | | | | |
| **Participant’s Nominee Contact (Next of Kin)** |  | | | | | | | |
| Appointed Guardian/NDIS Nominee | ☐ Yes | ☐ No | | | Copy of Guardian provided/ NDIS Nominee | |  | |
| First Name |  | | | | Last Name | |  | |
| Relation |  | | | | Phone Number | |  | |
| Address |  | | | | | | | |
| 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 | | | | ☐ Plan Managed | | ☐ Self-Managed | |
| Plan Manager Details (Organisation, Name, Contact Number, Email) |  | | | | | | | |
| Support Coordinator Details(Organisation, Name, Contact, Email) |  | | | | | | | |
| Local Area Coordinator Details(Organisation, Name, Contact, Email) |  | | | | | | | |
|  | | | | | | | | |
| **Allied Health Reports** | | | | | | | | |
| Occupational Therapist | ☐ Yes | ☐ No | | | Attached | | | |
| Physiotherapist | ☐ Yes | ☐ No | | | Attached | | | |
| Psychologist | ☐ Yes | ☐ No | | | Attached | | | |
| Psychiatrist | ☐ Yes | ☐ No | | | Attached | | | |
| Health Management Plan | ☐ Yes | ☐ No | | | Attached | | | |
| Other | ☐ Yes | ☐ No | | | Attached | | | |
|  | | | | | | | | |
| **My NDIS Goals** | | | | | | | | |
| Goal 1. |  | | | | | | | |
| Goal 2. |  | | | | | | | |
| Goal 3. |  | | | | | | | |
| Goal 4. |  | | | | | | | |
|  | | | | | | | | |
| **My Supports** | | | | | | | | |
| **Medication** | | | | | | | | |
| Do you take medication | ☐ Yes | ☐ No | | | Do you require SASS to administer medication | | ☐ Yes | ☐ No |
| Do you require support to fill or pop medication from a webster pack or pill box | ☐ Yes | ☐ No | | | Do you require support to obtain your medication from your pharmacy | | ☐ Yes | ☐ No |
| **Swallowing** | | | | | | | | |
| Do you have any swallowing difficulties | ☐ Yes | ☐ No | | | Do you have a Mealtime Management Plan | | ☐ Yes | ☐ No |
| Do you require your food/drinks to be adapted to your requirements? | ☐ Yes | ☐ No | | | Do you have a dietician plan | | ☐ Yes | ☐ No |
| **Hygiene** | | | | | | | | |
| Do you require support with Hygiene? | ☐ Yes | | ☐ No | | Details | | | |
| **Toileting** | | | | | | | | |
| Do you require assistance with toileting? | ☐ Yes | | ☐ No | | Details | | | |
| **Mobility** | | | | | | | | |
| Do you require mobilising or transferring? | ☐ Yes | | ☐ No | | Details | | | |
| **Transportation** | | | | | | | | |
| Do you require assistance with Transport? | ☐ Yes | | ☐ No | | Details | | | |
| **Positive Behaviour Support Plan** | | | | | | | | |
| Do you have a BSP? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have any restrictive practices in your BSP? | ☐ Yes | | ☐ No | | Details | | | |
| **High Intensity Activities** | | | | | | | | |
| Do you require High Intensity Supports? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have a Tracheostomy? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have a catheter? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have any complex wounds? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have a PEG tube? | ☐ Yes | | ☐ No | | Details | | | |
| Do you require complex bowel care? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have epilepsy/seizures? | ☐ Yes | | ☐ No | | Details | | | |
| Do you have diabetes? | ☐ Yes | | ☐ No | | Details | | | |
|  | | | | | | | | |
| **Support Needs** | | | | | | | | |
| ☐ Personal Care  ☐ Cleaning | ☐ Community Access  ☐ Make/Attend Appointments | | | | ☐ Cooking/Meal preparation  ☐ Gardening | | ☐ Companionship  ☐ Star Charts/Monitoring | |
| **Interests/Hobbies** | | | | | | | | |
| ☐ Music  ☐ Volunteering  ☐ Craft  ☐ Movies  ☐ Socialising | ☐ Eating Out  ☐ Sport  ☐ Gardening  ☐ Building/Wood Working  ☐ Fashion/shopping | | | | ☐ Card Games  ☐ Gym  ☐ Cooking  ☐ Video Games  ☐ Other | | ☐ Art  ☐ Dancing  ☐ Cleaning  ☐ Cars  ☐ Other | |
| **Preferred Worker** | | | | | | | | |
| ☐ Male | ☐ Female | | | | ☐ No Preference | | ☐ Other | |

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|  | | | | | | Establishment Fee to be charged ☐ Y ☐ N  (20 hrs or more per month) | | | |
| **NDIS Support Item Number** | **Cost per hour** | **Service Information**  (Times, Days & other Comments) | **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?** | **Are these times & days flexible? Y/N Suggestions?** |
| E.g. Access Community Social and Rec Activ - Weekday Daytime | 62.17 | Monday 12pm-3pm  Thursday 9am-12pm | Y | 20 kilometers | | | | NDIS Plan | Days aren’t flexible  Times can be flexible |
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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) | | | |  |
| **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* | | | | | | | | | |

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| **Who is Completing this Request for Services** | | | |
| Agency Name |  | | |
| Contact Person |  | Contact No. |  |
| Email |  | Mobile |  |
| Where Did you hear about SASS (Sharron Andrea Support Services)? | | | |
| ☐ Website  ☐ Social Media  ☐ Friend for Family  ☐ Other (please specify below) | | | |