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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-3pmThursday 9am-12pm | Y | 20 kilometers | NDIS Plan | Days aren’t flexibleTimes 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) |