Empowering Uniqueness with You Request For Services/Referral Form

Participant Details

First Name:		Surname:			
DOB:		Gender:		Pronoun:	
Address					
Street Name:		City/Sate:		Postcode:	
Contact Details					
Home:		Work:		Mobile:	
Primary Language:					
Email:		Country of Birth:			
Cultural Status					
Ethnicity					
Do you identify as an Aboriginal or Torres Strait Islander (please tick)		YES		NO	
Do you identify as Cultural and Linguistic? (please tick)		YES		NO	
Please note any cultural needs:					

NDIS Plan Details

NDIS Number:		**NDIS Plan Start Date:**	DD/MM/YY
How is this plan managed? (please tick) ( ) Plan Managed ( ) Self-Managed ( ) Agency-Managed		**NDIS Plan End Date:**	DD/MM/YY

Plan-Management Provider:	Provider Name:			
	Contact Person:			
	Address:		State:	Postcode:
	Phone:		Fax:	
	Email:			

Disability/Primary Diagnosis

(Provide the disability in which this support directly relates to and how it impacts your daily life)

Additional diagnosis/conditions

(This can be medical conditions that are not related to your primary diagnosis or not covered by NDIA, but may be covered by some other party ie. MAIB)

If you have any supporting documentation please add this to the RFS/Referral form to help us determine the suitable support worker to suit your preferences and experiences required to meet your needs.

Support Description

Regular supports: supports you will have regularly with Empowering Uniqueness with You.

(refer to the NDIS price guide, there is an opportunity to negotiate the rate)

Description *Eg Self-Care Activities*	**Support Schedule details** (Friday- Shopping)	**Line Item** *01_011_0107_1_1*	**Hourly Rate** *$65.47*	**Hours** *4*	**Weeks/Mths** 52 wk /12 mths
			$		
			$		
			$		
			$		
			$		
			$		
				Total Agreed	

*STA/Respite Support: support you would like once or twice with Empowering Uniqueness with You over the plan period.

The below is an initial guide as to what you are looking for and how we may support you based on the preliminary information below, it is subject to change, alternatively you may just request a quote.

(refer to the NDIS price guide, there is an opportunity to negotiate the rate)

Description STA And Assistance (Inc. Respite) - 1:1 - Weekday	**Line Item** 01_058_0115_1_1	**Day Rate** $2,033.53	**No. of Days** 4	**Total** $8,134.12
		$		
			Total Agreed	

*An itinerary of the respite can be developed with the participant and/or support coordinator, authorised representative on a separate page to match the above STA/Respite budget breakdown.

Request For Quote (RFQ)

Description (Self-Care, Community Access, Respite, Yard, House Maintenance, Personal Domestic etc)	**Support Schedule Details.** (Monday – Swimming)	**Hours you're wanting for each support of area** (4 hrs support with 1 hour for transport)	**Over x amount of days/weeks.** (2 days per week)	**Comments** (For example- this may change during the winter time)

Who do we contact to discuss RFS, RFQ?

Preferred first contact person?

Who	**Please tick**
Participant	
Plan Nominee	
Support Coordinator	
Guardian/Public Trustee/Other	

Contacting participant what is their preferred method to reach them?

Method	**Please tick**
Phone	
Email	
Mail	
Face to Face	

Contact Details for the preferred first contact:

First Name:		Surname:				
DOB:		Gender:		Pronoun:		
Street Name:		City/Sate:		Postcode:		
Home:		Work:		Mobile:		
Email:						

Reason for referral:

NDIS Goals:

Using the example below please outline the NDIS goals from the participants plan to ensure that supports are aware of what the NDIS have approved in funding to justify for our services. Not all the goals will relate to the service but can provide an idea of what the participant wishes to achieve overall during the plan period. This will also be referred in the progress notes and service provider report for documenting responsibilities.

SMART Goal *E.g. I would like to increase and maintain my independence and daily living skills*	**How will this be achieved** • *Support Coordinator to link and assist (participant) in engaging with services appropriate to her needs.* • *Occupational therapist to help (participant) to identify strategies, assistive technology or adaptive aids to promote independence and participation in daily activities.*	**Short/Med/Long Term** *(Short to Long Term)*

Additional Services Engaged With:

Please list below who else the participant is engaged with, and if GTS Care need to contact them on behalf or with the participant during i.e. participant requires support to attend a medical or allied health appointment as part of their independence and meeting their health and well-being. Can list General Practitioner, Mental Health Worker, Occupational therapist. Don't need to outline a lot of information as this will be revisited in the GTS Care Individual Support Plans. A consent to share or obtain information will be required to be signed when signing the service agreement.

Provider Name and Contact Person	Reason for engagement	Contact details (optional)

Behaviours of Concerns:

If there are presenting Behaviours that may be barriers to service implementation, it is important that we are aware of what they are so we are able to plan how we best support the participant and also more importantly match the right worker with the participant. A copy of the BSP Interim Plan, Functional Behavioural Comprehensive Plan may also be provided along with the RFS/Referral.

Behaviour of concern	Details

Consent:

Is the participant aware of the RFS, RFQ, Referral?

Yes	
No	

This is to certify that the above information has been provided with the participants knowledge/consent and is true and correct.

Name......

Signature: ..... **Date:** .....

Referrer Contact Details:

First Name:		Surname	
Work No.		Mobile No.	
Email:		Relationship:	

Office Use Only:

Accepted: Yes/No

Rejected: Yes/No

Pending Approval: (only use if the plan is in transition or plan review stage)

Estimated Start Date of Service:

Signature: ..... **Date:** .....

Melanie Morris
(Managing Director)