Participant Referral & Intake Form

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| 1. Referral Agency or Referrer’s Details | | | | |
| Name of Agency / Organisation  *(If Applicable):* | |  | | |
| Referrer’s Full Name: |  | | Referrer’s Relationship to Participant: |  |
| Referrer’s Title/ Position: |  | | Referrer’s Phone number: |  |
| Referrer’s email address: |  | | Referrer’s mobile number: |  |

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| 1. Participant’s Details | | | | | | | | | |
| Full Name: |  | | | | | | | D.O.B: |  |
| Gender: |  | | | | Preferred Pronouns: |  | | Ethnicity: |  |
| Preferred Language  (*If other than English)* | | | | |  | | Do you require an Interpreter? | | Yes  No |
| Are you Aboriginal &/or Torres Strait Islander origin? | | | | | Yes  No  Unsure / Unknown  Participant exercised their right to refuse to answer. | | | | |
| NDIS Ref. # |  | | | Plan Start Date: | |  | | Plan End Date: |  |
| Plan Funding Type: | | Agency Managed  Self-Managed  \*Self-funded.  *\*participant’s/plan nominee’s responsibility to pay invoices.*  \*\*Plan Managed \*\* Nominated Plan Manager:  \*Plan Manager’s contact email: | | | | | | | |
| Address: |  | | | | | | | | |
| Suburb: |  | | | | | | | Postcode: |  |
| Postal Address *(If the same as above, state ‘As Above’)* | | |  | | | | | | |
| Phone # |  | | | | | Mobile # | |  | |
| Email Address: | | |  | | | | | | |
| Living Arrangement: | | | With Parents  Independent  Private Rental  Supported Accommodation  Aged/Nursing Home  Others (please specify): | | | | | | |
| Services Required: | | | Support Coordination  Plan Management  Core Supports i.e.  Accommodation Access    Referral to Specialist Services  Advocacy i.e., support, advice,  i.e., Allied Health Therapists report writing for NDIS plan, reviews &  accessing the NDIS | | | | | | |

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| 1. Support Coordinator Details | |
| Coordinator Name: |  |
| Organisation: |  |
| Contact Number: |  |
| Email: |  |

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| 1. Guardian and/or Plan Nominee’s Details *(If different from above referrer)* | | | | | | | |
| Full Name: | |  | | | Relationship to Participant: | |  |
| Address: |  | | | | | | |
| Suburb: |  | | | | | Postcode: |  |
| Phone # |  | | | Mobile # | |  | |
| Email Address: | | |  | | | | |

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| 1. Support Times | | | |
| Please select when support is required. | | | |
|  | AM | PM | Timings/Number of support hours/Comments |
| Monday |  |  |  |
| Tuesday |  |  |  |
| Wednesday |  |  |  |
| Thursday |  |  |  |
| Friday |  |  |  |
| Saturday |  |  |  |
| Sunday |  |  |  |

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| 1. Staff Preference | | | | | | |
| Gender: | | Male | | Female | | No Preference |
| Specific skills required: | | | | | | |
| Medication | Urinary catheter | | Dementia | | Behaviours of concern | |
| Diabetes | Bowel care | | Epilepsy | | Transportation | |
| Other: | | | | | | |

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| 1. About the Participant | |
| About Me: |  |
| Likes: |  |
| Dislikes: |  |

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| 1. Goals | |
| Short-term: |  |
| Medium-term: |  |
| Long-term: |  |

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| 1. Disability | |
| Primary Disability: |  |
| Secondary Disability: |  |
| Any Other Health Alerts: |  |

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| 1. Medication | | |
| Does the Participant have regular medications? | Yes | No |
| Participant able to self-medicate. | Yes | No |
| If your answer was No, please attach a list of all medication’s participant require assistance with. | |

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| 1. Expressive Communication | | |
| The Participant is | Fully Verbal | Non-verbal |
| Other Considerations: |  | |

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| 1. Mobility | | | | |
| The Participant is | Independent | Non-ambulant | | Requires some supervision |
| Use of Mobility Aids: | Yes | | No | |
| Type of mobility Aid used: |  | | | |

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| 1. Eating | | |
| Able to self-feed: | Yes | No |
| Please list any special eating habit techniques or behaviours that require attention or support: |  | |

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| 1. Personal Care | | | | |
| Does the participant require personal care: | | Yes | | No |
| Toileting | Self-dress and grooming | | Incontinence Aids | |
| Showering/bathing | Use of hoist / equipment | | Overnight support | |

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| 1. Intake Process |
| **Support Coordination:**  Can take up to two weeks for the full intake process to be completed and to be allocated to a specific Support Coordinator who will be matched to meet the Participant’s individual needs.  Unmatched Support Services will organise an initial meeting with the Participant, to sign a Service Agreement and develop a Schedule of Supports directly in consultation with the Participant and/or Plan Nominee.  **Plan Management:**  Unmatched Support Services will set up Budget and send through a screenshot to the Support Coordinator (if not us). Claims and Payments will be made within 5 days of receipt of invoice.  **Core Supports:**  Unmatched Support Services Will arrange to allocate an experience support worker who meets the Participant’s individual needs. This process can take up to two weeks to occur.  **Advocacy:**  Advocacy is quite a complex process, and we appreciate the time it takes to get this process going. The advocacy work, that Unmatched Support Services Disability Support Services is completely not-for-profit and is solely supported by Government Funding and philanthropic grants. Unmatched Support Services goes through a process of deciding whether we can take on your case, through a panel. Once the panel decides that Unmatched Support Services can support the participant’s case, the process from intake to commencing the case, can take up to 6 weeks.  Unmatched Support Services appreciates your patience and thanks you in advance. |

**Client / Guardian / Plan Nominee Declaration**

*I consent to my information being provided to Unmatched Supporting Services for the purposes of referral, service delivery and inclusion in de-identified data reporting.*

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| Full Name of Client/Guardian/Plan Nominee |  |
| Signature of Client/Guardian/Plan Nominee | |

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| 1. Participant Intake Checklist |

Assessment Officer (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title / Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have explained the following information to (participant / plan nominee’s full name):

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Signed by assessment officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Topic** | **Tick** |
| Eligibility criteria for entry to the service, and procedures for prioritising access |  |
| Individual’s right to access a support person of their choice to assist them when entering or exiting a service, and in developing their personalised plan |  |
| Information and support which can be offered to assist individuals using the service |  |
| How the service works with individuals accessing services to develop a personalised plan to assist them to achieve their goals, and the format of the copy of the plan which will be provided to the individual accessing the service |  |
| Procedures for accessing or nominating a support person of their choice |  |
| Support which will be provided, how the support will be delivered, and how frequently the personalised plan will be reviewed |  |
| Privacy and confidentiality policy and procedures in relation to the use of, and access to personal information held about individual accessing services |  |
| Procedures for release of personal information to another party and the requirement for informed consent for release |  |
| How the individual accessing services can participate in decision making processes to assist the service to improve |  |

I confirm that the above information has been explained to me.

Signed by Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed by nominated Support Person / Plan Nominee / Approved Representative (if Participant is Unable to sign):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_