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
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| 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
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| Coordinator Name: |  |
| Organisation:  |  |
| Contact Number: |  |
| Email: |  |

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| 1. Guardian and/or Plan Nominee’s Details *(If different from above referrer)*
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| 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
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| 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
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| About Me: |  |
| Likes: |  |
| Dislikes: |  |

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

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

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| 1. Medication
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| 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
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| The Participant is  | [ ]  Fully Verbal | [ ]  Non-verbal |
| Other Considerations: |  |

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| 1. Mobility
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| 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
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| 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
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| **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
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Assessment Officer (print name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_