# Request for Service / Support Plan

**Please complete this Request for Service / Support Plan form with as much information as possible. The information you give us in this form will allow us to create a support plan designed for your individual needs. This will allow the team at Better Lives Support Services (BLSS) to provide you with the highest level of support and care.**

**Better Lives Support Services is a registered NDIS provider.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Support plan start date** |  | **Support plan R/V date** |  |

## Participant Details

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **NDIS #** |  |

|  |  |
| --- | --- |
| **Residential Address** |  |
| **Postal Address** |  |
| **Date of Birth** |  | **Age** |  |
| **Gender** | [ ]  **Male** | [ ]  **Female** | [ ]  **Other** |
| **Phone Number** |  | **Mobile Number** |  |
| **Email address** |  |

|  |  |
| --- | --- |
| **Support Coordinator****Name****Phone number** |  |
| **Local Area Coordinator (LAC)****Name:****Phone Number:**  |  |
| **Client Management: Plan, NDIA, Self-Funded**  |
| [ ]  Plan Managed | NDIA Managed | Self-Funded |
| **Client consents to release NDIS Plan to BLSS** |
| *A Consent form for the client to sign has been attached to this request – please return signed copy with request* | [ ]  Yes | [ ]  No |
| **Plan Manager / Managing Organisation - for supports requesting** |
| **Organisation** |  |
| **Contact Person** |  |
| **Contact Number** |  |
| **Contact Email** |  |

|  |
| --- |
| **Brief outline of Supports Requesting: (e.g. Medications, Cleaning, Socialising etc.)** |
|  |
| **NDIS Support Code(s) *(Relevant to participants NDIS Plan for supports requesting):*** |
|  |  |
|  |  |
|  |
| **Details for services Hours / Times required** | **Days of the week required** |
| **Morning Times** |  | **[ ] Mon [ ] Fri****[ ] Tue [ ] Sat****[ ] Wed [ ] Sun****[ ] Thu [ ] P/H’s** |
| **Afternoon Times** |  |
| **Night Times** |  |
| **24/7 Care** | **[ ]**  |
| **Total Days** |  per [ ] **Week** [ ] **Fortnight** [ ] **Month** |
| [ ] Until end of plan **Date:**  | [ ] Until specific date**Date:**  |
| **Any other relevant information?** |
|  |

# Participant Support Plan

## Short-Term Goal

## Medium-Term Goal

## Long-Term Goal

## Guardianship and OPA

|  |  |
| --- | --- |
| **Name**  | **Contact Details** |
| **Office of Public Advocate** |  |
| **Financial POA** |  |
| **Medical POA** |  |

**Aboriginal or Torres Strait Islander origin:**

[ ]  No

[ ]  Yes, Aboriginal

[ ]  Yes, Torres Strait Islander

[ ]  Yes, both Aboriginal and Torres Strait Islander

**Cultural background and Preferences**

**Preferred Language**

**Interpreter Required:**

[ ]  Yes [ ]  No

## Emergency Information

|  |  |
| --- | --- |
| **Name** |  |
| **Relationship**  |  |
| **Phone Number** |  |
| **Email Address** |  |

**Does the participant require assistance in an emergency?**

[ ]  Yes [ ]  No

If yes, please give a brief description or attach relevant document.

**Does the participant have a Personal Emergency Alarm?**

[ ]  Yes [ ]  No

If yes, please give brief description of the Personal Emergency Alarm.

|  |
| --- |
|  |

## GP Details

|  |  |
| --- | --- |
| **Name** |  |
| **Practice** |  |
| **Address** |  |
| **Phone Number** |  |
| **Email Address** |  |

## Pharmacist Details

|  |  |
| --- | --- |
| **Name** |  |
| **Practice** |  |
| **Address** |  |
| **Phone Number** |  |
| **Email Address** |  |

# Health and Medical Information

## Medications

**Does the participant take any medications?**

[ ]  Yes [ ]  No

**Does the participant require assistance or supervision with medications?**

[ ]  Yes [ ]  No

If the participant is taking medication, please list the current medications.

**Does the participant have any allergies?**

[ ]  Yes [ ]  No

If yes, then please give a brief description of the allergies.

**Please note if the allergy is severe/anaphylactic, a GP Anaphylaxis Action Plan**

**needs to be attached to this document.**

**Disability, Diagnosis or Medical Conditions (include mental health conditions)**

Please give a brief description of the participant’s disability, diagnosis, or medical conditions.

**COVID-19 Vaccination Status:**

[ ]  Has not received a COVID-19 vaccination

[ ]  1 dose of a COVID-19 vaccination

[ ]  2 doses of a COVID-19 vaccination

[ ]  3 doses/full vaccination including booster(s)

**Does the participant have a health or mental health care plan? If yes, please attach to this document.**

[ ]  Yes [ ]  No

**RISK ASSESSMENT**

**Completed by:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **COMMUNICATION** | **Yes** | **No** |  | **COGNITION** | **Yes** | **No** |
| Hearing Ok | [ ]  | [ ]  |  | Client willing to participate and assist in care | [ ]  | [ ]  |
| Speech Ok | [ ]  | [ ]  |  | Oriented in time and place | [ ]  | [ ]  |
| Able to write | [ ]  | [ ]  |  | Client able to accept direction and instruction | [ ]  | [ ]  |
| English language skills | [ ]  | [ ]  |  | Short-term memory issues | [ ]  | [ ]  |
| **Further Comments:** |  | **Further Comments:** |
|  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **MOBILITY & MANUAL HANDLING** | **Yes** | **No** |  | **PERSONAL CARE ASSISTANCE REQUIRED** | **Yes** | **No** |
| Walk unaided | [ ]  | [ ]  |  | Showering / Toileting | [ ]  | [ ]  |
| Manages stairs unaided | [ ]  | [ ]  |  | Grooming | [ ]  | [ ]  |
| Uses walking aid to walk | [ ]  | [ ]  |  | Eating | [ ]  | [ ]  |
| Uses wheelchair | [ ]  | [ ]  |  | Mouthcare | [ ]  | [ ]  |
| Is manual handling equipment in place and used | [ ]  | [ ]  |  | Skin care | [ ]  | [ ]  |
| **Further Comments:** |  | **Further Comments:** |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| **AGGRESSION / VIOLENCE** | **Yes** | **No** |
|  *H=History of C=Current Risk*  |
| Physical aggression to support worker | **H C****[ ]** **[ ]**  | **[ ]**  |
| Verbal aggression to support worker | **H C****[ ]  [ ]**  | **[ ]**  |
| Aggression to other clients | **H C****[ ]  [ ]**  | **[ ]**  |
| Aggression with/against objects | **H C****[ ]  [ ]**  | **[ ]**  |
| Self-harm | **H C****[ ]  [ ]**  | **[ ]**  |
| Substance abuse | **H C****[ ]  [ ]**  | **[ ]**  |
| Sexual abuse | **H C****[ ]  [ ]**  | **[ ]**  |
| Threats to staff in any way | **H C****[ ]  [ ]**  | **[ ]**  |
| Use of emotions to achieve goals | **H C****[ ]  [ ]**  | **[ ]**  |
| **Further Comments** |
|  |

## Risk Assessment Summary and Action Plan

|  |
| --- |
|  |

## Risk Assessment Reviews and Documented Changes

**Document any changes to increases in risk assessment and potential behaviours.**

|  |  |  |
| --- | --- | --- |
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|  |  |  |

# Primary Health Assessments and Allied Health

|  |  |  |  |
| --- | --- | --- | --- |
| **Discipline** | **Appointments** | **Dates/Review** | **Comments** |
| Dentist |  |  |  |
| Physiotherapist |  |  |  |
| OT |  |  |  |
| Podiatrist |  |  |  |
| Dietician |  |  |  |
| Optometrist |  |  |  |
| Diabetes Educator |  |  |  |
| Speech Pathologist |  |  |  |

**Does the participant have a medical directive? If yes, please attach to this document.**

[ ]  Yes [ ]  No

# About Your Home

Is the house easy to locate?

[ ]  Yes [ ]  No

Is onsite/street parking available for the support worker’s car?

[ ]  Yes [ ]  No

Are any gates or doorways difficult to use or access?

[ ]  Yes [ ]  No

At night, is the house entrance hard to find?

[ ]  Yes [ ]  No

Are there any slip, trip or falling hazards outside the home?

[ ]  Yes [ ]  No

Is the home wheelchair accessible?

[ ]  Yes [ ]  No

Are there any slip, trip or falling hazards inside the home?

[ ]  Yes [ ]  No

Will the support worker be required to use any electrical appliances?

[ ]  Yes [ ]  No

In case of any emergency in the home, please describe the emergency procedure for the support

worker to follow. Please consider any special procedures, nearest exits, and emergency meeting points.

Is there anything else you would like to share about the home?

# Community Participation

Are there any places, situations or specific irritants that should be avoided?

**Is there a risk that the participant may abscond?**

[ ]  Yes [ ]  No

Please provide details on how to manage this risk. Describe in detail if there is any way to prevent this from occurring.

If something goes wrong in the community, are there any specific emergency instructions for the support worker?

# Transport

**What type of transport will the participant use?**

[ ]  Public transport

[ ]  Participant’s own car (with the support worker driving)

[ ]  The support worker’s car

[ ]  Other

Are there any specific risks associated with transport?

If something goes wrong, are there any transport-specific emergency instructions for the support worker?

**Do you give consent for the support worker to proactively support you in attending medical and allied health services?**

[ ]  Yes [ ]  No

# Better Lives Support Services will take reasonable efforts to work with the participant in selecting their preferred support worker.

|  |  |
| --- | --- |
| **Participant’s Name** |  |
| **Participant’s Signature** |  |
| **Date** |  |

|  |  |
| --- | --- |
| **Participant Representative’s Name** |  |
| **Participant Representative’s Signature** |  |
| **Date** |  |

Thank you for your referral.

**Please return the completed referral form to:** contact@blss.net.au

Once returned we will make every effort to contact you as soon as possible.

Kind Regards,

Better Lives Support Services

**Please complete the consent form on next page.**

# Consent Form

Consent for Better Lives Support Services (BLSS) to speak to the following people to get information regarding setting up my support plan:

* Support Coordinator
* Plan Manager
* Participant Representative

## Name of Participant/Representative

| **Full name of Participant or Participant Representative** |  |
| --- | --- |
| **If Representative,** **please indicate role** |  |
| **Preferred contact details (phone, email, etc.)** |  |

**Please tick the relevant box below to indicate the length of time you are providing the consent for:**

[ ]  Once only

[ ]  For the duration of my current NDIS plan

[ ]  For a set time ending (DD/MM/YYYY):

[ ]  Ongoing

|  |  |
| --- | --- |
| **Name** |  |
| **Signature** |  |
| **Date** |  |

**Return form via:**

**Email:** contact@blss.net.au

**In person:** 44A George Street, Moe, Victoria 3825