gatewayhealth

NDIS COMMUNITY INCLUSION - REQUEST FOR SERVICES

About the NDIS Participant

NDIS Number		**Request Date**	
Preferred Title	☐ Miss ☐ Master ☐ Ms ☐ Mrs ☐ Mr ☐ Other ☐ N/A		
First Name		**Surname**	
Telephone		**Mobile**	
Email		**Date of Birth**	
Address			
Preferred Worker	☐ Male ☐ Female ☐ No Preference		
Indigenous Status	☐ Aboriginal ☐ Torres Strait Islander	**Preferred Language**	
	☐ Both ☐ Neither	**Interpreter Required**	☐ Yes ☐ No
Cultural Considerations			
For participants under the age of 18yrs - Are there any court orders in regards to custody or any Child Protection Orders in place? (If yes, please supply a copy)			☐ Yes ☐ No
Disability Information	☐ Psychosocial		
	☐ Intellectual		
	☐ Autism		
	☐ Physical		
	☐ Other		

NDIS Participant's Nominee Contact

Name			
Address			
Telephone		**Mobile**	
Email			

NDIS Participant's Primary Contact regarding arrangements for these supports

Name			
Address			
Telephone		**Mobile**	
Email			

About the NDIS Plan

Start Date		**End Date**	
Plan Included	☐ Yes	☐ No (Please specify goals if no plan provided)	
Participant Goals (Please List)			
Billing Details	☐ NDIA	☐ Third Party	☐ Self-Managed
Plan Manager or Self Management Details (Name, Contact, Email)			

Who is Completing this Request for Service

Agency Name			
Contact Person		**Contact No.**	

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Community Inclusion

☐ Disability & Psychosocial Support ☐ Safe & Sound Protocol Program

NDIS Support Item Category Start & Finish Date of Service	How many hours per service?	Frequency of Service	Transport Required?		How many kms are required for support with the Participant?	What Days do you require this support	What time of the day do you require the support?	**Please state what this support is for, the more details the better:** e.g. To be picked up & dropped off by worker and taken to the supermarket, collect medication from pharmacy and have morning tea at a cafe. Worker to assist me when home to unpack my shopping.
			Yes	No				
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				
			☐	☐				

Number of Weeks of service for the plan period? ☐ 50 week (No service in the weeks of Christmas & New Years) ☐ 52 week (All Year) ☐ Other

If the support falls on a Public Holiday, would you still like to be supported? (Please Note: This will be charged at the Public Holiday Rates for that particular day) ☐ Yes ☐ No

What is the estimated date you would like services to commence? (Please Note: Commencement at Gateway Health is due to staff availability and our intake process)