Calvary | Kooyong Precinct Health Care Bethlehem

CHCB UR:

NDIS Provider Service Request for NDIS Supports

476 Kooyong Road, Caulfield South VIC 3162

NDIS Coordinator phone number: (03) 9834 9358
Email: BethlehemNDIS@calvarycare.org.au

Instructions for completing this form:

1. Complete all fields in the form. This form may be completed by the participant or on behalf of the participant.
2. Email form, including a copy of the current NDIS plan to BethlehemNDIS@calvarycare.org.au
3. The NDIS plan or screenshots of the relevant budgets is essential for evidence of funding available. If this is not included, the referral will not progress

Confirmation of the referral received will be provided by email within 3 working days. This form will be scanned into the participant's CHCB medical record. Information in this form will be kept private and confidential.

Person completing form: Date:

1. NDIS Participant:

First name		Phone	
Surname		Email	
Date of Birth		Country of birth	
Address	Street address		
	Town/city	Post code	
Is the participant known to Calvary Health Care Bethlehem from current or previous services received?	No: ☐ If yes, tick all that apply: Community Palliative Care ☐ Inpatient Service ☐ Clinic (SPNDS) ☐ NDIS Provider Service ☐		
Does the participant have an emergency and disaster management plan?	Yes: ☐ *If yes please provide us with a copy No: ☐ Comments:		
Does the participant have an Advanced Care Plan?	Yes: ☐ *if yes please provide a copy No: ☐		
Does the participant identify as Aboriginal and/or Torres Strait Islander?		Yes: ☐ No: ☐	
Does the participant require an interpreter?	Yes: ☐ No: ☐	*If yes, state preferred language:*	
Who should we contact to discuss setting up supports and appointments? Participant ☐ Alternative contact ☐	Alternative contact name		
	Phone/email		
	Relationship to participant		

2. Decision Maker:

Is there another person appointed to make decisions on behalf of the participant? **Not Applicable** ☐

Name		Relationship to participant	
Phone number		Email	
Decision-making capacity *(plan nominee, power of attorney, guardian etc.)*			

3. Support Coordinator: Not Applicable ☐

Name		Organisation	
Phone Email		Working days	

4. NDIS Plan: *Please attach copy of current NDIS plan or relevant sections

NDIS number			
NDIS Plan Dates	Start date:	End date:	
How are the funds in the Capacity building budget of the plan set up? *Tick multiple if more than one applies where several supports are being arranged*	NDIA ☐ *(Agency managed)*	Plan managed ☐	Self-managed ☐
		Plan Manager name:	Person receiving invoices:
		Email address for invoices:	Email address for invoices:

Does current plan include funding periods? (increments or block funding) Yes: ☐ No: ☐

5. NDIS Plan Goals: *List relevant NDIS Plan goals or provide a copy of the NDIS plan

6. Relevant Participant Information: *Description of current function and other supports/services involved*

7. Reason for referral

8. Supports requested:

State supports required, goals/issues to address, allocation of funding/hours if known

	Support requested and hours allocated per funding period					
	Dietetics	**Dietetics (HEN)*** *5 hours	**OT**	**Physio**	**Speech Pathology**	**Neuropsychology*** *Improved daily living only for behaviour support please complete supplementary form
Budget	Choose Improved Health ar	Choose Improved Healtl	Choose Improved Daily Li	Choose Improved Daily	Choose Improved Daily Livi	Improved Daily Living *min 15 hours required in first period
Funding period						