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| 1. Agency Details
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| **Referral Date:**  |  |
| **Name of Referrer:**  |  |
| **Referrers Agency:**  |  |
| **Postal Address:**  |  |
| **Phone:**  |  |
| **Email:**  |  |

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| 1. Participant Details
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| **Name of Participant:** |  |  |  |
| **Address of Participant:** |  |
| **Telephone of Participant:** |  |
| **Date of Birth:** |  | **Gender:**   |  |
| **Marital Status:** | ☐ Single ☐ Married ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Does the participant identify as:**☐ Aboriginal☐ Torres Strait Islander☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Country of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Language at Home:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Disability:** ☐ Yes ☐ No

**Description:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Medical Management Plans must be provided (Diabetes plan, Epilepsy plan, Asthma plan etc)*

**Behaviours of Concern / Restrictive Practices:** ☐ Yes ☐ No

*If Yes, we will forward you a Risk Assessment form to complete prior to sending a quote*

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| 1. Funding Information
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| **NDIS Number:** |  |
| **Plan Dates:** |  |
| **Plan Manager Email for Invoices:** |  |
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| 1. General Information
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| **Service required:**

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| ☐ | 0115 **Daily Tasks/Shared Living (Respite/Short Term Accommodation)** |
| ☐ | 0115 **Daily Tasks/Shared Living (Medium Term Accommodation)** |
| ☐ | 0107 **Assistance with Daily Life (Assistance with Self Care)** |
| ☐ | 0115 **Home and Living (SIL)**  |
| ☐ | 0125 **Social and Community Participation** |
| ☐ | 0125 **Assist-Travel/Transport** |
| ☐ | 0136 **Group and Centre Based Activities** |
| ☐ | 0116 **Innovative Community Participation** |

Please complete the below as required **0115** **Daily Tasks/Shared Living (Respite)****Ratio required:** *Note: Ratios are taken into consideration for group outings. We will quote for a provision of 1:1-day support rates for participants on 1:2 and 1:3 ratios if they decide not to join the group outing during their stay.* ☐ **1:1 – Requires Full Assistance with Daily Tasks*** Showering
* Toileting
* Dressing and undressing
* Mobility assistance in the community
* Behaviours that require full monitoring (eyes on, constant need for staff attention)
* Requires full assistance and constant supervision in the community.
* 1:1 Staff member present throughout a 24hr period

*Does not include Active Overnight. If you require Active Overnights, please call to discuss* *prior.* **☐ 1:2 – Requires Some Assistance with Daily Tasks*** Minimal showering assistance (assistance to get in and out of bath or shower)
* Minimal personal care and dressing (assistance with, shoes, socks, hair brushing)
* May require prompting to pick appropriate clothes and get ready for the day.
* Supervision or occasional help eating or using cutlery.
* May need staff to help with daily living choices.
* Requires closer supervision in the community and on outings.
* Can effectively join with a group on agreed upon outings for a period of up to 8 hours

**☐ 1:3 – Independent or Requires Prompting with Daily Tasks** * A person who is independent in all areas of personal care including toileting, showering and brushing teeth
* Can eat independently, make drinks for themselves and has good communication/social skills.
* Understands road rules, social settings and can effectively join with a group on agreed upon outings for a period of up to 8 hours
* Able to spend periods of time alone while staff attend to other duties

*Full Description of ratios and assistance required to be discussed with Wattle Tree Office staff if you have ticked 1:1 or 1:2 Ratio* *Please note that if a participant requires more than the ticked ratio a phone call will be made to request a change to the original quote and must be signed off before the stay can continue.* **Do you require Wattle Tree to provide transport to and from Respite/STA?** ☐ Yes ☐ No **Preferred Days / Dates for supports:**☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

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**Reason for Referral:** |  |  |  |
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| **Participant Desired Outcome:**  |
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| **Where did you hear about us?**  |  |
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|  |  |  |  |
| **Name:**  |  | **Date:**  |  |
| **Signature:**  |  |  |  |