

BEHAVIOUR SUPPORT REFERRAL FORM FOR NDIS PARTICIPANTS

Participant Name:			
Date of Birth:		Gender:	Male, female, non-binary, trans
Phone:			
Email:			
Address:			
Country of Birth:			
Indigenous / Ethnicity	<input type="checkbox"/> Aboriginal, Torres Strait Islander <input type="checkbox"/> Not of indigenous origin <input type="checkbox"/> Other ethnicity (specify) _____		
NDIS Number:			
NDIS Plan Start Date:		NDIS Plan End Date:	
NDIS Plan Copy Attached	<input type="checkbox"/> Yes (If yes, please attach) <input type="checkbox"/> No		
Behaviour Support Plan:	<input type="checkbox"/> Yes (If yes, please attach) <input type="checkbox"/> No		
Living Arrangements:	<input type="checkbox"/> Alone <input type="checkbox"/> With Family <input type="checkbox"/> Other (please specify)		
Who is the primary Contact? <input type="checkbox"/> NOK <input type="checkbox"/> Carer <input type="checkbox"/> Guardian	Name:		
	Phone:		
	Relationship:		
	Other information:		

2. Referrer Details

Name:	Organisation:
Phone:	Email:
Role: (please tick) <input type="checkbox"/> Support coordinator <input type="checkbox"/> Professional <input type="checkbox"/> Family member	
Other: (please specify) _____	

3. Diagnosis / Presenting Issues

Please attach any relevant reports

Diagnosis:

(Please specify: Drug & Alcohol Abuse/ Intellectual Disability/ Disability/ Medical/ Mental Health and other presenting issues)

Details regarding Behaviours of Concern:

Goal / s of Behaviour Support Intervention:

Risks for the participant in transitioning to WeSupportU?

4. Funding Available for Behaviour Support

Please outline the funding available for the following components of the intervention. Please note the total funding allocated must include 10 hours of report writing for an end of plan or closure report. If unsure about the funding available, please ensure this is discussed with the Support Coordinator or LAC.

1. Functional Behaviour Analysis and Development of a Behaviour Support Plan

These tasks are funded under Capacity Building Improved Relationships - Specialised Behaviour Support 11_022 at a current charge rate of **\$214.41p/h**:

- Where there are no restrictive practices and the plan is to be utilised at home or school we require a minimum of **30 hours**
-
- Where there are no restrictive practices and the plan is to be utilised in an out-of-home care setting we require a minimum of **35 hours**
-
- Where there are restrictive practices and the plan requires authorisation we require a minimum of **40 hours**.

Funding available: _____

2. Training and Ongoing Support

This is a critical part of the intervention to train the individual and their supports in understanding and utilising the behaviour management strategies outlined in the behaviour support plan.

This is funded under Capacity Building Improved Relationships – Behaviour Support training 11_023 at a current charge rate of **\$193.99p/h**.

Funding available: _____

3. Individual Social Skills Development

Individual Social Skills Development assists participants to develop their social skills for participation in community and social activity.

This is funded under Capacity Building Improved Relationships – Individual Social Skills Development 11_024 at a current charge rate of **\$74.63p/h**.

Funding available: _____

- PLEASE create a service agreement and/or service booking for all the funds allocated under Improved relationships**

Alternate Funding

In the event there is no funding available for Behaviour Support under Capacity Building Improved Relationships and you feel behaviour support is required, we may be able to provide an Assessment and Recommendation for possible future Improved Relationships funding.

This is funded under Capacity Building - Improved Daily Living
Assessment Recommendation Therapy or Training –

- Other professional (15_056) \$193.99,
- Psychologist (15_054) \$214.41,
- Social Worker (15_621) \$193.99,
- Occupational Therapist (15_617) \$193.99.

If required – please advise on the available funding. Specify _____

A minimum of 15-20 hours is required to complete an assessment and provide a report.

5. Home Visit Screening Questions (for the safety of our staff, it is mandatory this section is completed in full)

Is anyone at the client's property known to be aggressive or violent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you aware of there being firearms at the property? Is yes, are they locked away securely?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you aware of any occupant having an infectious disease (i.e. Chicken pox/Shingles/Gastro, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you aware of any risks related to pets or animals on the premises?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone in the house smoke? If yes, are they happy to refrain from smoking while the therapist's visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the house easy to find/is parking available? If NO, please provide suggestions on where best to park:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any other factors we should be aware of visiting this client at home on our own? If YES, please describe:	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Other Services Involved

Service Name	Service Contact	Contact Details
Paediatrician		
Psychologist		
School		
Occupational Therapist		

Service Name	Service Contact	Contact Details
Speech Pathologist		
Other		
Support Coordinator		
Mental Health		
DFFH		
Drug & Alcohol		
Orange Door		
Corrections / Justice		

7. Inclusive Service Needs

WeSupportU is an inclusive provider. We welcome referrals from all participants so please let us know if there are any considerations relating to culture, religion, values, beliefs and sexual expression that we can accommodate:

8. *Payment Of Account*

Who is responsible for paying the account? *(please tick)*

NDIS portal

I authorise for WeSupportU to create a Service Booking for the hours nominated above.

Plan Manager *(if plan managed, please complete details below)*

Name of Plan Management Organisation: _____

Email for invoices: _____

Phone: _____

Self-managed *(if self-managed please complete details below)*

Name of person responsible for the account: _____

Email for invoices: _____

Phone: _____

9. *Additional Information (if applicable):*

10. Signature

Person completing this form:

Please insert your name below as your electronic signature or sign this document to authorise for Intensive Therapeutic Support services to commence based on the information provided in this form:

Print name/sign: _____ Date: _____

Client/guardian declaration:

I consent to my information being provided to WeSupportU for the purposes of referral, service delivery and inclusion in de-identifying data reporting.

Full Name: _____ Date: _____

Signature of Client/Guardian: _____

I consent to the fees and charges outlined on this form and acknowledge that these might increase in line with any new NDIS charge rates. I will be advised of any increase by my allocated worker.

Full Name: _____ Date: _____

Signature of Client/Guardian: _____

Please note that the information provided above will assist WeSupportU to assess whether we are the appropriate agency to best meet the participants/ your needs. It does not guarantee automatic services provision.

It is WeSupportU policy that a signed Service Agreement is in place for all NDIS participants prior to commencement of service delivery. If the participant and WeSupportU staff agree to work together, a Service Agreement will be sent via email using PandaDoc document signing or will be bought for an in person signing during a first visit.

If a Service Agreement is subsequently received and the agreed role or cost of services differs to the above, our records will be updated to reflect the changes in the signed Service Agreement.

Please return completed form to: intake@wesupportu.com.au