About the NDIS Participant				
NDIS Number			Request Date	
First Name			Middle Name	
Surname			Preferred Name	
Phone Number			Mobile Number	
Email Address			Date of Birth	
Address				
Disability Type	☐ Psychosocial ☐ Autism		☐ Intellectual ☐ Physical	☑ Mental Health ☐ Other - Specify
Secondary Condition	☐ Psychosocial ☐ Autism		☐ Intellectual ☐ Physical	☐ Mental Health ☐ Other - Specify
Preferred Worker				
Indigenous Status	☐ Aboriginal	☐ Torres Strait Islander	☐ Both	☐ Neither
Communication	☐ Verbal	☐ Gestures	☐ Communication Aids	☐ Sign Language
My preferred method of contact	☐ Phone	☐ Face to Face	☐ Email	☐ SMS
Interpreter Required	☐ Yes ☐ No		Preferred Language	
Cultural Considerations				
Who I live with	☐ I live alone ☐ SRS		☐ I live with family ☐ SDA	☐ Aged Care ☐ Other - Specify
Participant's Nominee Contact (Next of Kin)				
Appointed Guardian/NDIS Nominee	☐ Yes ☐ No		Copy of Guardian provided/ NDIS Nominee	
First Name			Last Name	
Relation			Phone Number	
Address				
Email			Alternative Contact	
About the NDIS Plan				
Start Date			End Date	
Plan Included	☐ Yes		☐ No (Please specify goals if not plan provided	
Billing Details	☐ NDIA		☐ Plan Managed	☐ Self-Managed
Plan Manager Details (Organisation, Name, Contact Number, Email)				

Support Coordinator Details(Organisation, Name, Contact, Email)	

Allied Health Reports					
Occupational Therapist	☐ Yes	☐ No	Attached		
Physiotherapist	☐ Yes	☐ No	Attached		
Psychologist	☐ Yes	☐ No	Attached		
Psychiatrist	☐ Yes	☐ No	Attached		
Health Management Plan	☐ Yes	☐ No	Attached		
Other	☐ Yes	☐ No	Attached		
My NDIS Goals					
Goal 1.					
Goal 2.					
Goal 3.					
Goal 4.					
My Supports					
Medication					
Do you take medication	☐ Yes	☐ No	Do you require GSS to administer medication	☐ Yes	☐ No
Do you require support to fill or dispense medication from a webster pack or pill box	☐ Yes	☐ No	Do you require support to obtain your medication from your pharmacy	☐ Yes	☐ No
Swallowing					
Do you have any swallowing difficulties	☐ Yes	☐ No	Do you have a Mealtime Management Plan	☐ Yes	☐ No
Do you require your food/drinks to be adapted to your requirements?	☐ Yes	☐ No	Do you have a dietician plan	☐ Yes	☐ No

Hygiene			
Do you require support with Hygiene?	☐ Yes	☐ No	Details
Toileting			
Do you require assistance with toileting?	☐ Yes	☐ No	Details
Mobility			
Do you require mobilising or transferring?	☐ Yes	☐ No	Details
Transportation			
Do you require assistance with Transport?	☐ Yes ☐ Car seat required?	☐ No	Details
Positive Behaviour Support Plan			
Do you have a BSP?	☐ Yes	☐ No	Details
Do you have any restrictive practices in your BSP?	☐ Yes	☐ No	Details
High Intensity Activities			
Do you require High Intensity Supports?	☐ Yes	☐ No	Details
Do you have a Tracheostomy?	☐ Yes	☐ No	Details
Do you have a catheter?	☐ Yes	☐ No	Details
Do you have any complex wounds?	☐ Yes	☐ No	Details
Do you have a PEG tube?	☐ Yes	☐ No	Details
Do you require complex bowel care?	☐ Yes	☐ No	Details
Do you have epilepsy/seizures?	☐ Yes	☐ No	Details
Do you have diabetes?	☐ Yes	☐ No	Details
Support Needs			
☐ Personal Care	☐ Community Access	☐ Cooking/Meal preparation	☐ Companionship

☐ Cleaning	☐ Make/Attend Appointments	☐ Gardening	☐ Star Charts/Monitoring
Interests/Hobbies			
☐ Music ☐ Volunteering ☐ Craft ☐ Movies ☐ Socialising	☐ Eating Out ☐ Sport ☐ Gardening ☐ Building/Wood Working ☐ Fashion/shopping	☐ Card Games ☐ Gym ☐ Cooking ☐ Video Games ☐ Other	☐ Art ☐ Dancing ☐ Cleaning ☐ Cars ☐ Other
Preferred Worker			
☐ Male	☐ Female	☐ No Preference	☐ Other

				Establishment Fee to be charged (20 hrs or more per month) ☐ Y ☐ N		
NDIS Support Item Number	**Cost per hour**	**Service Information** (Times, Days & other Comments)	**Transport Required? Y/N**	**How many km are required for travel per supports?**	**Is transport to be self-funded by participant or the NDIS Plan to be used?**	**Are these times & days flexible? Y/N Suggestions?**
E.g. Access Community Social and Rec Activ - Weekday Daytime	62.17	Monday 12pm-3pm Thursday 9am-12pm	Y	20 kilometers	NDIS Plan	Days aren't flexible Times can be flexible
Number of Weeks of Service for the Plan Period?			☐ 50 weeks (No Service in the weeks of Christmas & New Years)	☐ 52 Weeks (All Year)	☐ Other	☐ Until end of Plan
If the support falls on Public Holiday, would you still like to be supported? (Please Note: This will be charged at the public Holiday Rates for the particular day)			☐ Yes ☐ No	**What is the estimated date you would like service to commence?** (Please Note: Commencement at GSS is due to staff availability and our intake process)		
For initial assessment GSS (Gippsland Support Services) requires a minimum allocation of 2 (two) hours per shift *Personal Care, transfers/Manual Handling is 2 hours* *Please speak with our Director or Program Managers if you have any concerns about minimum GSS hours*						

Who is Completing this Request for Services			
Agency Name			
Contact Person		Contact No.	
Email		Mobile	
Where Did you hear about GSS?			
☐ Website ☐ Social Media ☐ Friend for Family ☐ Other (please specify below)			