Participant Referral /Application for Support Services

1. Participant Details

Date of Referral/Application: ____ / ____ / _____

Title:
☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other: _____

Last Name: _____

Given Names: _____

Preferred Name: _____

Gender:

☐ Female ☐ Male ☐ non-binary ☐ Prefer not to say

☐ Other: _____

Date of Birth: ____ / ____ / _____ **Age:** _____

Address: _____

_____

Suburb: _____ **Postcode:** _____

Mobile Phone: _____

Home Phone: _____

Email: _____

Language/s Spoken Other Than English: _____

Interpreter Required: ☐ Yes ☐ No

Office Use Only: *Date, time & place of scheduled meeting*

Cultural Identity:

☐ Aboriginal

☐ Torres Strait Islander

☐ Aboriginal & Torres Strait Islander

☐ Culturally and Linguistically Diverse (CALD)

☐ None of the above

☐ Prefer not to answer

Current Living Situation - Lives With:

☐ Family

☐ Alone

☐ Friends/Housemates

☐ Partner

☐ Other: _____

Current Living Arrangements:

☐ Supported Independent Living (SIL)

☐ Supported Residential Living

☐ Own Home

☐ Private Rental

☐ State Housing

☐ Other: _____

2. Assisting Person / Guardian / Nominee Details (If applicable)

Role/Relationship to Participant:

☐ Assisting Person

☐ Enduring Guardian

☐ NDIA Nominee

☐ Power of Attorney (PoA)

☐ Public Guardian

☐ Other: _____

Please attach supporting documentation where applicable.

Name: _____

Phone: _____

Email: _____

Declaration

I declare that I have the participant's consent to make this referral/application and provide MIHS with the participant's personal, medical and support information.

Signature: _____

Date: ____ / ____ / _____

3. Referrer Details (if different from participant)

Name: _____

Organisation/Role: _____

Relationship to Participant: _____

Phone: _____

Email: _____

4. NDIS Details

NDIS Participant Number: _____

Plan Start Date:

Plan Review Date:

Funding Arrangement

☐ Agency Managed

☐ Plan Managed

☐ Self-Managed

Plan Manager Details (if applicable)

Plan Manager Name: _____

Organisation/Role: _____

Phone: _____

Email for Invoices: _____

4. Reason for Referral / Application

_____

_____

_____

_____

_____

5. Participant Goals

(as stated in the NDIS Plan and related to supports being requested)

Goal 1:

_____

Goal 2:

_____

Goal 3:

_____

Goal 4:

_____

6. Support Services Requested

Accommodation / Respite

☐ Short Term Respite
Details: _____

In-Home Support

☐ Personal care

☐ Domestic assistance

☐ Meal preparation

☐ Medication support

☐ Appointment assistance

☐ Community access

☐ Other: _____

Details: _____

_____

Social & Community Participation

Details: _____

_____

Day Support / Group Programs

☐ Day Centre attendance

☐ Group activities

☐ Community outings

Ratio of Support Required

☐ 1:1

☐ 1:2

☐ Other: _____

Preferred Days / Times: _____

7. About Me (Participant Profile)

Please tell us about:

- Your interests and hobbies
- Activities you enjoy
- Things you dislike
- Any preferences that help staff support you well

Examples may include:

Cooking, movies, cafes, music, gaming, reading, shopping, exercise, swimming, gardening, fishing, walking, volunteering, group activities, quiet spaces, sensory preferences, etc.

_____

_____

_____

_____

_____

_____

8. Diagnosis Information

Diagnosis Details (such as physical, mental, health, intellectual) Type	**Details of the Treatment / Support Required**

9. Medical Overview

9a. Complex Medical/Health Needs

☐ Yes ☐ No ☐ Unknown

Examples: PEG feeding, indwelling urinary catheter, stoma, oxygen support, seizures, diabetes management.

Details:

_____

_____

9b. Prescribed Medication

☐ Yes ☐ No ☐ Unknown

Please provide the details below or attach a copy of medication chart/list:

_____

_____

9c. Allied Health / Other Health Supports

☐ Yes ☐ No ☐ Unknown

Details:

_____

_____

10. Communication

Communication Style

☐ Verbal

☐ non-verbal

☐ Uses communication device

☐ Sign language

☐ Communication book/cards

☐ Other: _____

Additional Information:

_____

_____

_____

11. Supports, Mobility and Independence

11a. Special Dietary Requirements

☐ Yes ☐ No ☐ Unknown

Details (If participant has a Meal Management Plan please provide a copy with your referral): -

11b. Mobility Aids or Equipment

☐ Yes ☐ No ☐ Unknown

Examples: wheelchair, walker, hoist, shower chair.

Details:

_____

_____

11c. Personal Care Support Required

☐ Yes ☐ No ☐ Unknown

Details:

_____

_____

12. Behaviour Support Overview

12a. Current Behaviours of Concern

☐ Yes ☐ No ☐ Unknown

Details:

_____

_____

12b. Previous Behaviours of Concern

☐ Yes ☐ No ☐ Unknown

Details:

_____

_____

12c. Positive Behaviour Support Plan (PBSP)

☐ Yes ☐ No ☐ Unknown

Please attach a copy of the current plan.

12d. Restrictive Practices

☐ Yes ☐ No ☐ Unknown

Details:

_____

13. Risk Overview

Please indicate if any of the following apply:

Risk Area	Yes	No	Unknown
Self-harm or suicidal ideation			
Acute mental health concerns			
Alcohol or other drug concerns			
Contact with justice system			
Physical or verbal aggression			
Hospital admissions in past 2 years			
Other identified risks			

Additional Risk Information:

_____

_____

14. Supporting Documentation Attached

☐ NDIS Plan

☐ Meal Management Plan

☐ Behaviour Support Plan

☐ Medication Chart

☐ Allied Health Reports (Physiotherapist / Occupational Therapist / Speech Therapist

☐ Care Plan – GP Health Plan / Comprehensive Health Care Plan

☐ Risk Assessments

☐ Guardianship/PoA Documents

☐ Other: _____

15. Participant Consent and Privacy

We require your consent to collect personal information about you. MIHS is committed to protecting the privacy and security of any personal information it obtains about individuals. MIHS complies with the Privacy Act, 1988 and the Personal Information Protection Act 2004 (Tas). I understand that the information provided in this referral/application form will be collected, stored and used by **Making It Happen Support (MIHS)** for the purpose of assessing and delivering support services. I consent to MIHS collecting, using, storing and sharing my personal, health and support information with relevant persons or organisations where required to provide supports and services.

Participant Name: _____

Participant Signature: _____

Date: ____ / ____ / _____

If signed by another person on behalf of the participant:

Name: _____

Relationship to Participant: _____

Signature: _____

16. How Did You Hear About Making IT Happen Support?

☐ Family/Friend ☐ Support Coordinator ☐ Local Area Coordinator (LAC)

☐ NDIA ☐ Website/Social Media ☐ Other: _____

Office Use Only

Date Received: ____ / ____ / _____ **Received By:** _____

Outcome:

☐ Accepted for intake

☐ Waitlist

☐ Further information required

☐ Not suitable at this time

Notes:

_____

Submission Information

Please return completed referrals/applications and supporting documents to:

Email: admin@makingithappensupport.com Attention: Sharen Best

Post:
Attention: Sharen Best
PO Box 590
Glenorchy TAS 7010

Hand Delivery:
Attention: Sharen Best
MIHS Day Centre

Thank you for your referral/application to **Making It Happen Support**.

A member of our team will contact you if further information is required.