chosen family

Referral Form

Chosen Family *Chosen Family offers diverse support services—from community access to personal care—empowering you to live your best, most independent life.*

---

1. Participant Information

Participant Name:

First: _____ Last: _____

Preferred Name: _____

Gender Identity:

☐ Male ☐ Female ☐ Non-binary ☐ Gender Diverse ☐ Transgender ☐ Other: _____

Contact Details:

Phone Number: _____

Date of Birth (DD/MM/YYYY): _____

Participant Email: _____

Residential Address:

Full Address: _____

Suburb: _____ State: _____ Postcode: _____

chosen family

2. Service Requirements

Communication Preferences:

Does the client consent to be contacted? ☐ Yes ☐ No

Best person to contact:

Name: _____

Best mode of communication: ☐ Text/SMS ☐ Phone Call ☐ Email

Diagnosis & Consent:

Primary & Secondary Diagnosis: _____

Consenting Person's Name: _____

3. Guardianship & Support Coordination

Is the participant with the Public Trustee and Guardian? ☐ Yes ☐ No

Guardian Details (if applicable):

Name: _____

Phone: _____

Email: _____

chosenfamily

Relation to Participant:

☐ Parent ☐ Guardian ☐ Public Guardian ☐ Power of Attorney ☐ Other

Support Coordinator Details:

Company Name: _____

Name: _____

Email: _____

Phone: _____

---

4. Schedule of Support

Outline preferred hours (Start/Finish times).

Day	Start Time	Finish Time	Day	Start Time	Finish Time
Monday			Friday		
Tuesday			Saturday		
Wednesday			Sunday		
Thursday					

chosenfamily

What type of services is the client seeking? (Select all that apply):

- ☐ Community Access
- ☐ Household Tasks
- ☐ SDA
- ☐ SIL Accommodation
- ☐ Capacity Building
- ☐ STA/Respite
- ☐ Drop in Support
- ☐ Personal Care
- ☐ LGBTQIA+ Training
- ☐ Support Coordination (Lvl 2)
- ☐ Support Coordination (Lvl 3)
- ☐ Other: _____

Which line items will Chosen Family be claiming for in this schedule of supports?
Please list all with funding amounts for each support provided max a week:

_____
_____
_____
_____

chosenfamily

5. NDIS & Payment Details

NDIS Number: _____

Plan Dates: _____ to _____

NDIS Plan Management:

☐ Self-managed ☐ Plan managed ☐ NDIA Managed

Hours of support allowed per week: _____

Plan Manager (if applicable):

Company Name: _____

Name: _____

Email: _____

Mobile: _____

Payment Method:

☐ Option 1: Participant/Nominee managed (Provider sends invoice)
☐ Option 2: NDIA Managed (Provider claims from NDIA)
☐ Option 3: Registered Plan Management Provider

chosenfamily

6. Additional Client Details

Care & Mobility:

- High care needs? ☐ Yes ☐ No
  Details: _____
- Mobile? ☐ Yes ☐ No
  Details: _____
- Manual handling/Hoists? ☐ Yes ☐ No
  Details: _____
- Mobility Equipment (Walkers, etc)? ☐ Yes ☐ No
  Details: _____
- Feeding requirements (Tube)? ☐ Yes ☐ No
  Details: _____

Behavior & Environment:

- Behavioral issues? ☐ Yes ☐ No
  Details: _____
- Work with Pets? ☐ Yes ☐ No
  Specify: _____
- Preferences: ☐ Smoker ☐ Non-smoker

NDIS Goals & Service Start Date:

Goals: _____ Proposed Commencement Date: _____

chosenfamily

Has anyone referred you to Chosen Family? if so, please provide their name : _____