Territory Community Services

SUPPORTED INDEPENDENT LIVING REQUEST FOR SERVICE FORM

SECTION 1: PARTICIPANT INFORMATION

Participant's full name:		Date of birth:	
Other names: (if applicable)		Gender:	Male Female
Residential address:			
Postal address: (if different)			
Contact numbers:	Home:	Mobile:	
Does the participant identify as:	Aboriginal Torres Strait Islander Neither		
Has the Participant consented to this referral?	Yes No		
Primary diagnosis / disability: (please attach supporting documentation)			
Secondary disability(ies) or other presenting issues:			
Communication status: (eg. verbal, sign etc)			
Communication assessment:	Completed and attached Not available Not applicable		
Personal mobility aids:			
Mobility aids required:	Hoisting Commode Sarah Steady Any other Assistive Devices _____		
Does Participant have challenging behaviours?			
Does participant have a current Behaviour Support Plan (PBSP)?	Yes Dated _____ (please provide a copy) → Has a PBSP review been requested: Yes No No → Is a PBSP required: Yes No		

Please tick the documents that have been provided:

PBSP	Risk assessment	Person centred plan
NDIS plan goals	Communication assessment	Occupational Therapy assessment
Copy of NDIS Plan (optional, assists in planning)	Other (provide details) _____	

SECTION 2: RATIO OF CARE AND COMMUNITY ACCESS

Requested ratio of support:

Day:	1:1	1:2	1:3	Other _____		
Night:	1:1	1:2	1:3	Other _____	Passive	Active
Community Access:	1:1	1:2	1:3	Other _____		

Current community access / Day service

Monday	Hour/time _____	Activity _____
Tuesday	Hour/time _____	Activity _____
Wednesday	Hour/time _____	Activity _____
Thursday	Hour/time _____	Activity _____
Friday	Hour/time _____	Activity _____
Saturday	Hour/time _____	Activity _____
Sunday	Hour/time _____	Activity _____

SECTION 3: NDIS PLAN

NDIS Plan approved:	Yes	Pending (waiting NDIS response)	Not commenced		Not applicable
NDIS number:		Plan start date:		Plan end date:	

If not NDIS funded, what is the funding source?_____

NDIS COS Details				
Name:		Organisation:		
Email:			Phone:	
Plan Management:	Agency managed	Plan managed	Self-managed	
If Plan Managed, contact details of Plan Manager:				
Name:		Organisation:		
Email:			Phone:	

SECTION 5: CONTACT DETAILS			
Participant / Parent / Guardian:			
Address:		Contact numbers:	H: M:
Email:			
Signature:		Date:	

SECTION 5: REFERRER DETAILS			
Relationship to client:	Guardian (completed above, no further details required) Coordinator of Supports (complete referrer details)		
Organisation:		Contact numbers:	B: M:
Name:			
Postal address:			
Email:			
Signature:		Date:	

Please send the completed referral form to: