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| Purpose |
| South West Disability Services (SWTAFE) seek your assistance to identify what is important to you and how you would like to be supported. This form is designed to obtain the relevant information to provide you with quality and individualised support. |

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| Privacy and Confidentiality |
| Information disclosed in this form will **NOT** be disclosed to any outside person or organization without prior written or verbal consent from yourself or nominee/ representative, as per the Privacy Act 1988.  SDWS may be obligated to collect data and details on behalf of the Government or other agencies, this information will be passed on when requested. Information may also be used or disclosed in circumstances related to public interest such as Law enforcement or health and safety related issues as noted within SWTAFE Privacy Policy. |

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| How to complete this form. |
| This form should be completed by you, your parent/ caregiver, nominee or representative. Where appropriate it may also include support of a Support Coordinator and/or formal advocate.  Stage 1- Complete online direct or complete Personal details and support requirements below  Stage 2- Consent  Stage 3- Office use only |

**STAGE 1**

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| --- | --- |
| Online intake completed | Yes  No- complete Stage 1 |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Personal Details and Support Requirements | | | | | | | |
| Full Name |  | | | | | | |
| Gender |  | Date of Birth | | |  | | |
| Address |  | | | | | | |
| Suburb |  | | | | | | |
| Mailing Address (if difference to home address) |  | | | | | | |
| Home Phone |  | Mobile | | |  | | |
| Email Address |  | | | | | | |
| Cultural background |  | | Main language spoken at home | | | |  |
| Interpreter required | Yes  No | | Communication tools utlised | | | | Yes  No  Notes: |
| Do you identity as: | Aboriginal  Torres Strait Islander | | | | | | |
| Preferred contact method | Telephone  text/ SMS  Email  Post Other | | | | | | |
| Medicare Number |  | | | Expiry Date | |  | |
| Healthcare Card |  | | | Expiry Date | |  | |
| Companion card |  | | | Taxi Card | |  | |
| Private Health Insurance | Yes  No Details: | | | | | | |
| State Trustee: | Yes  No Details: | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency Contact | | | |
| Full Name |  | Relationship |  |
| Address |  | Post Code |  |
| Home phone |  | Mobile |  |
| Work Phone |  | Email |  |
| Interpreter Required | Yes  No | Language spoken |  |
| Notes: |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name |  | Relationship |  |
| Address |  | Post Code |  |
| Home phone |  | Mobile |  |
| Work Phone |  | Email |  |
| Interpreter Required | Yes  No | Language spoken |  |
| Notes: |  | | |
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| Living Arrangements | |
| I currently live in | Private home or Flat Emergency/ transitional housing  Supported accommodation Other: |
| I currently live with | on my own family/friends  Other |

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| --- | --- | --- | --- | --- | --- | --- |
| Funding | | | | | | |
| NDIS Plan Dates | |  | NDIS Number: | | |  |
| Plan attached | | Yes  No | Goals attached | | | Yes  No |
| DHHS package | |  | TAC- ID Number | | |  |
| Other | |  | | | | |
| Funding Contact:  Self  Other | | | | | | |
| Name |  | | | Number |  | |
| Address |  | | | | | |
| Email |  | | | | | |

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| --- | --- |
| Daily Support Requirements | |
| Mobility | |
| Independent mobility  Requires support sitting  Requires support transferring  Requires support mobilising  Requires support positioning | Notes: |
| Communication | |
| Uses verbal communication  Uses non-verbal communication  Vision Impairment  Hearing Impairment  Communication Aid  Hearing Aid | Notes: |
| Eating and Nutrition | |
| Eats independently  Requires assistance preparing meals  utilising utensils  Modified fluids  Modified foods  PEG- Percutaneous Endoscopic Gastrostomy  Swallowing Impairment  Diet plan Restrictions | Notes: |
| Toiletry & Personal Hygiene | |
| Requires assistance with Bladder management  Requires assistance with bowel management  Requires assistance with female hygiene | Notes: |
| Personal Care | |
| Requires assistance with bathing/ showing  Requires assistance with grooming  Requires assistance with un/dressing  Requires assistance with skin care  Requires assistance with clothing choices  Requires podiatry assistance | Notes: |
| Independence | |
| Requires assistance with choice making  Requires assistance with finances | Notes: |
| What I like | What I dislike |
|  |  |
| When I am happy I…… | When I am sad I……. |
|  |  |

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| Emergency Evacuation Support | |
| In the event of an emergency, would you be able to follow support worker direction to exit the building safely? | Yes  No Details |

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| --- | --- |
| Medical | |
| Condition |  |
| Medication taken | Yes  No Details |
|  | |
| Condition |  |
| Medication taken | Yes  No Details |
|  | |
| Condition |  |
| Medication taken | Yes  No Details |

|  |  |  |  |
| --- | --- | --- | --- |
| Behaviours | | | |
| Behaviour |  | | |
| Behaviour strategies |  | | |
|  |  | | |
| Behaviour |  | | |
| Behaviour strategies |  | | |
|  |  | | |
| Behaviour Support plan  (BSP) | Yes  No | Consent to view BSP | Yes  No |

|  |  |
| --- | --- |
| Goals | |
| Goal and strategies | Goal:  Strategy: |
| Goal and strategies | Goal:  Strategy: |

|  |  |  |
| --- | --- | --- |
| Consent | | |
| By signing below I confirm that South West Disability Service have advised me of the following:   * South West Disability Services Privacy and Confidentiality Policy * My rights to access personal information * My right to withdraw consent at any time * My information may be shared with other services/agencies, including data collection by the government in order to improve quality of care * If I am under the age of 18 or am unable to sign this document, a parent/carer/ nominee or representative may sign on my behalf. | | |
| Consent approval | | |
| Full Consent | Yes | |
|  | | |
| Part Consent | Yes | |
| Please list consent approval | |  |
| No Consent | Yes | |

|  |  |
| --- | --- |
| **PERSONS or AGENCIES WITH WHOM INFORMATION CAN BE OBTAINED &/or SHARED**: | |
| **Please add to the below list as required** | |
| 1. SWTAFE specialist Teaching staff | Obtain Share |
| 1. NDIA/Latrobe Community Health | Obtain Share |
|  | Obtain Share |
|  | Obtain Share |
|  | Obtain Share |
|  | Obtain Share |
|  | Obtain Share |

**STAGE 2**

|  |  |
| --- | --- |
| Intake check list |  |
| The following has been shared with me in a way that I understand: | Please tick |
| * Eligibility criteria for entry to the service, and procedures for prioritising access |  |
| * Support which will be provided, how the support will be delivered, and how frequently my support profile will be reviewed |  |
| * How the participant accessing services can participate in decision making processes to assist the service to improve |  |
| * Information if I choose to exit the service in the future |  |

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| Declaration | | | |
| By signing below I agree that all the above information I have provided, is accurate and current. | | | |
| Participant name |  | | |
| Signature |  | Date |  |
|  |  | | |
| Carer/ representative name |  | | |
| Signature |  | Date |  |

**OFFICE USE ONLY**

**STAGE 3**

|  |  |
| --- | --- |
| Further information | |
| Follow up: | Date |
|  |  |

|  |  |
| --- | --- |
| A copy of following has been provided | |
|  | Copy of participant handbook |
|  | Copy of individual Service Agreement |
|  | Copy of SDWS Privacy Policy |
|  | Copy of ‘*Its ok to complain’* brochure |
|  | Copy of Abuse and Neglect |
|  | Copy of Advocacy list |

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| Actions-Required | | **COMPLETED-** date |
|  | Medication Management Form |  |
|  | Medication Administration Record |  |
|  | Personal Emergency Evacuation Plan |  |
|  | Individual Support Sign off |  |
|  | **Support Worker Training**  **Notes:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Department acknowledgement | | | |
| SWDS Representative |  | | |
| Signature |  | Date |  |