



Health Care Bethlehem

### NDIS Provider Service

## Request for NDIS Supports

Address: 152 Como Parade West, Parkdale, VIC, 3195

NDIS Coordinator phone number: (03) 9595 3230

Email: [BethlehemNDIS@calvarycare.org.au](mailto:BethlehemNDIS@calvarycare.org.au)

U.R. Number _____
Surname _____
Other names _____
D.O.B _____

<p><b>Instructions for completing this form:</b>          Please email completed form with a copy of the current NDIS plan (email above)          This form may be completed by the participant or on behalf of the participant          This form will be scanned into the participant's CHCB medical record          Information in this form will be kept private and confidential and only used for the purpose of accessing and setting up supports</p>	<p>Office Use Only:          Date request received: _____           Accepted <input type="checkbox"/> Not Accepted <input type="checkbox"/>          Comments: _____</p>
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Person completing form: \_\_\_\_\_ Date: \_\_\_\_\_

### 1. NDIS Participant Details:

First name			Phone		
Surname			Email		
Date of Birth			Country of birth		
Address	Street address				
	Town/city		Post code		
Is the participant known to Calvary Health Care Bethlehem from current or previous services received?	No: <input type="checkbox"/> If yes, tick all that apply: Clinic (SPNDS) <input type="checkbox"/> NDIS Provider Service <input type="checkbox"/> Community Palliative Care <input type="checkbox"/> Inpatient Service <input type="checkbox"/>				
Does the participant identify as Aboriginal and/or Torres Strait Islander?					Yes: <input type="checkbox"/> No: <input type="checkbox"/>
Does the participant require an interpreter?	Yes: <input type="checkbox"/> No: <input type="checkbox"/>	If yes, state preferred language: _____			
Who should we contact to discuss setting up services and appointments? Participant <input type="checkbox"/> Alternative contact <input type="checkbox"/>	Alternative contact name				
	Phone/email				
	Relationship to participant				

### 2. Decision Maker Details

Is there another person appointed to make decisions on behalf of the participant? **Not Applicable**

Name			Relationship to participant		
Phone number			Email		
Decision-making capacity ( <i>plan nominee, power of attorney, guardian etc.</i> )					

**3. NDIS Plan Details:** *\*Please attach copy of current NDIS plan or relevant sections*

NDIS number			
NDIS Plan Dates	Start date:	End date:	
How are the funds in the Capacity building budget of the plan set up?  <i>Tick multiple if more than one applies where several supports are being arranged</i>	NDIA <input type="checkbox"/>	Plan managed <input type="checkbox"/>	Self-managed <input type="checkbox"/>
	(Agency managed)	Plan manager name/company:	Person receiving invoices:
		Email address for invoices:	Email address for invoices:

**4. Support Coordinator Details** Not Applicable

Name		Organisation	
Phone		Email	

**5. Home Environment and Alerts**

Who lives on the property?	
Are there any alerts or considerations for visits to the property?	

**6. NDIS Plan Goals**

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**7. Relevant Participant Information**

*State diagnosis, brief description of current function and other supports/services involved*

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**8. Supports requested**

*State supports required, goals/issues to address, allocation of funding/hours if known*

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