**CONFIDENTIAL:** Sensitive

|  |
| --- |
| Purpose  |
| South West Disability Services (SWTAFE) seek your assistance in identifying what is important to you and how you would like to be supported. Our team will use this information to make sure you get the right support. |

|  |
| --- |
| Privacy and Confidentiality |
| Information disclosed in this form will **NOT** be disclosed to any outside person or organisation 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. |

|  |
| --- |
| 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. This form is broken down by color and information type Personal Details  Support Requirements Emergency Management  Payments and Costs  Consent  Signature  Office Use  |

|  |
| --- |
| **Personal Details and Support Requirements** |
| Full Name |  |
| Gender |  | Date of Birth  |  |
| Pronoun |  ☐ she/her ☐ he/him ☐ they/them ☐ ze/hir Other:  |
| Address |  |
| Suburb |  |
| Mailing Address (if difference to home address) |  |
| Home Phone  |  | Mobile  |  |
| Email Address |  |
| Cultural background/religion  |  | Main language spoken at home |  |
| Interpreter required |  ☐ Yes ☐ No | Communication tools utilized |  ☐ Yes ☐ No Notes:       |
| Do you identify as: | ☐ Aboriginal ☐ Torres Strait Islander  |
| Preferred contact method  | ☐ Telephone ☐ Text/ SMS ☐ Email ☐ Post ☐Other       |
| State Trustee:  | ☐ Yes ☐ No Details:       |
| **Living Arrangements**  |
| I currently live in  | ☐ Private home or Flat ☐Emergency/ transitional housing☐ Supported accommodation Other:       |
| I live with  | ☐ myself ☐family/friends ☐ other      |

My goal with SWDS and TAFE is to…………

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Daily Support Requirements**  |
| Mobility |
| [ ]  Independent mobility [ ]  Requires support sitting[ ]  Requires support transferring[ ]  Requires support mobilising[ ]  Requires support positioning | Notes:       |
| Communication |
| [ ]  Verbal communication[ ]  Non-verbal communication[ ]  Vision Impairment[ ]  Hearing Impairment[ ]  Communication Aid[ ]  Hearing Aid | Notes:       |
| Eating and Nutrition  |
| [ ]  Independently [ ]  Assistance preparing meals [ ]  Utilising utensils [ ]  Modified fluids [ ]  Modified foods [ ]  PEG- Percutaneous Endoscopic Gastrostomy [ ]  Swallowing impairment [ ]  Diet plan restrictions  | Notes:  |
| Toiletry & Personal Hygiene |
| [ ]  Assistance with bladder management [ ]  Assistance with bowel management [ ]  Assistance with female hygiene | Notes:       |
| Personal Care |
| [ ]  Assistance with bathing/ showing [ ]  Assistance with grooming [ ]  Assistance with un/dressing[ ]  Assistance with skincare [ ]  Assistance with clothing choices[ ]  Podiatry assistance  | Notes:       |
| Independence  |
| [ ]  Assistance with choice making [ ]  Assistance with finances | Notes:       |
| My ideal support team:  | Personal Care only [ ]  |
| [ ]  Female [ ]  Male[ ]  No preference  | [ ]  Under 30 [ ]  30 - 50[ ]  Over 50 |
| What I like | What I dislike  |
|  |  |
| When I am happy I……  | When I am sad I……. |
|       |       |
| **Medical**  |
| Condition  |  |
| Medication taken | [ ] Yes [ ]  No Details       |
|  |
| Condition  |  |
| Medication taken | [ ] Yes [ ]  No Details       |
|  |
| **Behavior** |
| Behaviour Support Plan  | [ ] Yes [ ]  No  | Consent to view BSP  | [ ] Yes [ ]  No  |
| Behaviour Strategies  |  |
| Behaviour Strategies |  |

|  |
| --- |
| **Emergency Management** |
| Emergency Contact:  |
| Full Name |  | Relationship  |  |
| Address |  | Post Code  |       |
| Home phone  |       | Mobile  |  |
| Work Phone  |       | Email  |       |
| Interpreter Required  |  [ ]  Yes [ ]  No | Language spoken  |  |
| **Emergency and Disaster Management:** Call my emergency contact in the event of:  |
| [ ]  Illness [ ]  Medical Emergency [ ]  Campus Evacuation [ ]  Community Emergency [ ]  Emergency/change at residence |
| Notes:  |       |
| Emergency Contact: |
| Full Name |  | Relationship  |       |
| Address |       | Post Code  |       |
| Home phone  |       | Mobile  |       |
| Work Phone  |       | Email  |       |
| Interpreter Required  |  [ ]  Yes [ ]  No | Language spoken  |       |
| Notes:  |       |
| **Emergency and Disaster Management:** Call my emergency contact in the event of: |
| [ ]  Illness [ ]  Medical Emergency [ ]  Campus Evacuation [ ]  Community Emergency [ ]  Emergency/change at residence |
| **Primary Service Provider?**  |
| Will SWDS be your primary service provider? *A primary service provide is the main source of support and interaction.*  | [ ] Yes [ ]  No Details       |
| Do you have a current emergency management plan? | [ ] Yes [ ]  No Details       |

|  |
| --- |
| **Payment and Costs:** |
| NDIS Plan Dates |       | NDIS Number:  |  |
| Funding Contact: [ ]  Self [ ]  Other |
| Name  |  | Number  |  |
| Address  |  |
| Email  |  |
| Plan Use: | Have you committed your funding to another provider? [ ]  Yes [ ]  No Will your NDIS plan support your attendance at SWDS for the length of your service schedule? [ ]  Yes [ ]  No Do you give permission for SWDS/SWTAFE to be a provider of your choice?[ ]  Yes [ ]  No Quote provided $ |

|  |
| --- |
| **Consent**  |
| By signing below, I confirm that South West Disability Service has advised me of the following: * South West TAFE Privacy 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 the 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.
* In addition to speaking with others listed I also give permission for SWDS and TAFE
* to take my picture
* to use pictures in marketing material
* to use work created within supports
 |
| **Consent approval**  |
| Full Consent  | [ ] Yes  |
|  |
| Part Consent  | [ ] Yes  |
| Please list consent approval  |       |
| No Consent  | [ ] Yes   |
|  |  |
| **The people I say you can speak with are:**  |
| 1.
 | [ ]  Obtain [ ] Share |
| 1.
 | [ ]  Obtain [ ] Share |
| 1.
 | [ ]  Obtain [ ] Share |
| 1.
 | [ ]  Obtain [ ] Share |
| 1.
 | [ ]  Obtain [ ] Share |
| 1.
 | [ ]  Obtain [ ] Share |

|  |
| --- |
| **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 prioritizing 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
 | [ ]  |

|  |
| --- |
| **Declaration**  |
| By signing below, I agree that all the above information I have provided is true |
| Participant name  |  |
| Signature  |       | Date  |       |
|  |  |
| Carer/ representative name  |       |
| Signature  |       | Date  |       |

**OFFICE USE ONLY**

|  |
| --- |
| Follow up: |
|  |

|  |
| --- |
| A copy of following has been provided  |
| [ ]  | Copy of participant handbook  |
| [ ]  | Copy of individual Service Schedule and Statement of Agreement  |
| [ ]  | Copy of SWTAFE Privacy Policy  |
| [ ]  | Copy of ‘*Its ok to complain’* brochure  |
| [ ]  | Copy of Abuse and Neglect  |
| [ ]  | Copy of Advocacy list |
| [ ]  | Does not with to take documents  |
| [ ]  | Confirmed understanding of the documents in place |

|  |
| --- |
| Actions-Required  |
| [ ]  | Medication Management Form  |
| [ ]  | Medication Administration Record  |
| [ ]  | Personal Emergency Evacuation Plan  |
| [ ]  | Money Management log |
| [ ]  | Individual Support Sign off  |
| [ ]  | Emergency Management Plan |
| [ ]  | **Support Worker Training** **Notes:**  |

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