NDIS Participant – My Support Plan

Participant Details	
Name:	
Date of Birth:	NDIS Number:
Address:	Home Phone: Mobile: Work Phone: Email:
IN THE EVENT OF AN EMERGENCY PLEASE CONTACT 000 FOLLOWED BY ONE OF MY FAMILY MEMBERS	
Contact 1:	Contact 2:
Ensure to inform my Case Manager/Coordinator on:	
IF I DO NOT RESPOND TO SCHEDULED VISIT	
AAQ staff: If no response by the participant on arrival notify the Case Manager/Coordinator **Case Manager/Coordinator:** Phone participant. If no response phone the following contacts who live nearby:	
Contact 1:	Contact 2:
Is there a key safe to access the premises? ☐ Yes ☐ No If Yes, what is the Code: If unable to contact participant – phone local hospital. If not located, then notify police. If medical attention is required, an ambulance will be called.	
Living Arrangements	
Who do you live with?	
Living environment:	☐ Private ☐Rental ☐ Housing Commission ☐ SIL ☐ SDA ☐ Aged Care
Has the environment been modified to meet your needs? ☐ Yes ☐ No *If yes, please specify below*	
Carer Details	
Name: *(if applicable)*	
Address:	Home Phone: Mobile: Work Phone: Email:
Medical Information	
Allergies:	Alerts:

Diagnosis:	Date of Diagnosis:
Medical History:	
Doctors Details	
Full Name:	Practice Name:
Address:	Work Phone: Mobile: Email:
Goals	
What is important to you?	What are your goals for the next 12 months?

Services provided by AAQ are:

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
0600 – 0700 am							
0700 – 0800 am							
0800 – 0900 am							
0900 – 1000 am							
1000 – 1100 am							
1100 – 1200 am							
1200 – 0100 pm							
0100 – 0200 pm							
0200 – 0300 pm							
0300 – 0400 pm							
0400 – 0500 pm							
0500 – 0600 pm							
0600 – 0700 pm							
0700 – 0800 pm							
0800 – 0900 pm							
0900 – 1000 pm							
1000 pm +							

Functional Requirements

*NB: Functional Requirements marked with an * require the appropriate clinical assessment to be completed.*

Activity	**Tick** *(one)*	**Domestic and Personal Care**	**Provide details of the aids and assistance required, from whom and when**
Housework	☐	Can maintain home without help (including laundry)	
	☐	Need some assistance (cleaner, change light bulb)	
	☐	Completely unable to do housework	
Transport	☐	No help needed (drives own car, or travels independently on public transport or by taxi)	
	☐	Need some help (someone to drive or accompany when travelling)	
	☐	Can only travel in specialised vehicle	
Shopping (has transport)	☐	Can take care of all shopping needs on own (including internet shopping)	
	☐	Need some help (someone to accompany on most shopping trips)	
	☐	Completely unable to do any shopping	
Meal Preparation	☐	No help needed (can plan, prepare, cook, and ensure nutrition)	
	☐	Need some help	
	☐	Completely unable to prepare meals and manage nutrition	
Eating	☐	No help needed	
	☐	Some help needed (cutting up food, spreading butter, pouring drink, modified cutlery)	
	☐	Completely unable to eat without help (spoon feeding)	
*Taking Oral Medication	☐	No help needed (right dose and right time)	
	☐	Need some help (someone prepares, reminds, pre-packed)	
	☐	Completely unable to take own medicines without help	
Handling Money	☐	No help needed (banking, paying bills, keeping track of finances)	
	☐	Need some help (can manage day by day buying but needs help with paying bills)	

	☐	Completely unable to manage money	
Activity	**Tick** *(one)*	**Domestic and Personal Care**	**Provide details of the aids and assistance required, from whom and when**
Telephone	☐	No help needed (can make and receive phone calls including using assistive devices)	
	☐	Needs some help	
	☐	Completely unable to use telephone	
*Mobility	☐	No help needed (except use of stick)	
	☐	Need some help (person, walker, crutches, or self-propelled wheelchair including cornering)	
	☐	Completely unable to walk or needs to be pushed in wheelchair	
*Transfers Bed/Chair	☐	No help needed	
	☐	Need some help (person or equipment)	
	☐	Unable to manage (unable to balance while sitting)	
*Bathing Showering	☐	No help needed (get in and out of bath/shower and wash unaided)	
	☐	Need some help (rails, shower chair, person to shampoo hair but can wash themselves)	
	☐	Completely unable to bathe/shower on own	
*Oral Care	☐	No help needed (includes using electric toothbrush)	
	☐	Need some help (prompting)	
	☐	Completely unable to manage mouth care and cleaning teeth	
*Dressing	☐	No help needed	
	☐	Need some help (zips, buttons, laces but can put on some garments)	
	☐	Completely unable to dress	
*Grooming (makeup, hair, nails, shaving)	☐	No help needed	
	☐	Some help needed	
	☐	Completely unable to manage any grooming without help	

Activity	Tick *(one)*	Domestic and Personal Care	Provide details of the aids and assistance required, from whom and when
*Toileting	☐	No help needed (can get on and off, remove clothing and clean thoroughly)	
	☐	Need some help	
	☐	Completely unable to manage toileting without help	
Health Requirements			
Activity	**Tick**		**Outline condition, treatments, aids/assistance required, from whom and when**
*Continence	☐	Continent with regular bowel and bladder action	
	☐	Constipation, diarrhoea, or incontinence (using medication, supplements, pads)	
	☐	Medical interventions (catheter, stoma bag)	
*Skin Integrity	☐	No skin problems	
	☐	Some skin problems (rash, skin treatments)	
	☐	Pressure areas (currently have, at risk, or had in past)	
*Swallowing	☐	No swallowing issues	
	☐	Some swallowing problems (choking, coughing during normal meal, reduced appetite)	
	☐	Major swallowing difficulties (modified diet, feeding tube)	
Health professionals	☐	Have had a GP check up in the last 12 months	
	☐	See a specialist regularly	
	☐	Have a case manager/support coordinator	
Muscular Pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	

Activity	Tick		Outline condition, treatments, aids/assistance required, from whom and when
Nerve Pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	
*Falls	☐	No falls in past 12 months	
	☐	Less than 3 falls and no serious injury from a fall in past 12 months	
	☐	More than 3 falls or a serious injury from a fall in the past year	
Muscular issues (other than pain)	☐	No problems	
	☐	Some muscle weakness, tremor, spasms, spasticity, or problems with balance	
	☐	Serious muscle weakness, tremor, spasticity, or problems with balance	
Other health concerns	☐	Fatigue	
	☐	Visual disturbance	
	☐	Temperature intolerance	
	☐	Other comorbidities	

Social Requirements

Activities	Outline how you want to do this activity	Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)
Example: *I love cooking.*	• *I like to watch cooking shows on TV* • *I like to buy good cookbooks* • *I like to prepare my own meals* • *I like to attend cooking classes regularly*	• *I need a TV in my room with good reception* • *I need a computer/tablet and high speed internet or Wi-Fi to buy books online* • *I would like to have access to a kitchen to prepare my own meals 2 x per week* • *I need a maxi taxi and carer/staff member to take me to cooking classes once a month*
Family:		

Hobbies and Interests:		
Outings: *(theatre, cafes, exhibitions, drives, group activities)*		
Computer: *(games, shopping, education, bookings)*		
Employment *Education, Volunteering*		
Sports:		
Music: *(likes/dislikes)*		
Movies/TV: *(likes/dislikes)*		

Well-being: *(exercise, gym, swimming pool, massage, yoga, meditation etc.)*		
Food and alcohol: *(likes/dislikes/diets)*		
Other:		

Behavioural Requirements

Issue	Tick	Assistance I need	Outline the issue, aids, assistance, and management strategies required
Communication	☐	No assistance required (including independent use of aids and adaptive technology)	
	☐	Some assistance required (prompting, assistance with aids)	
	☐	Assistance always required	
Memory problems/confusion	☐	No	
	☐	Yes	
Concentration problems	☐	No	
	☐	Yes	
Planning problems	☐	No	
	☐	Yes	
Spiritual needs	☐	No	
	☐	Yes (name religion or spiritual affiliation and requirements)	
	☐	Mostly positive	

Mood	☐	Experiences sadness, anxiety, or emptiness around 50% of time	
		Feelings of anxiety, sadness or emptiness lasting most of the day , nearly everyday	
Decision making	☐	No help needed	
	☐	Need some help	
	☐	Not able to make any decisions	
Do you have a Will?	☐	No	
	☐	Yes	
Do you have an Enduring Power of Attorney?	☐	No	
	☐	Yes	
Do you have an Advanced Care Plan?	☐	No	
	☐	Yes	

What things are important for people to understand about you when caring for you?	Provide details	Outline how you like this to be managed
Who makes the decisions?		
What routines do you have?		
What make you happy?		
What helps you relax?		

What causes you stress?		
What makes you frustrated?		
What makes you angry?		
Other		

Service Direction

I hereby acknowledge that I am a partner:

- Who has choice and flexibility in the way care and services are provided to me, based on my assessed need, which will assist me to achieve my agreed goals documented in this My Support Plan;
- Who has an understanding of the role of my NDIS Case Manager/Coordinator and the services and support I will be receiving;
- Negotiated my involvement in administration tasks and the fees payable in relation to these;
- That received information about how my care fees and costs are calculated as stated in my Service Agreement.

I hereby agree to:

- Receive the services as negotiated in My Support Plan and acknowledge that it has been reviewed according to my needs;
- Contributing to the administration of my support;
- Consult with NDIS Case Manager/Coordinator if changes need to be made to services and My Support Plan.

PARTICIPANTS INVOLVED IN THE DEVELOPMENT OF MY SUPPORT PLAN

Participant:	Signature:
Date:	
Representative:	Signature:
Date:	
NDIS Case Manager/ Coordinator:	Signature:
Date:	