Comprehensive Client Support Documentation

Pause Feel Breathe Reflect Choose

Type of service required e.g. Respite, Camp, Community Access, Equine Facilitated Therapy

Participants outcomes they are seeking support for:

Transport required yes / no

Participant Name: Any previous names:	First	Middle	Surname
Address:	Phone:	Email:	
Date of Birth:	Gender:	Age:	
City or Town of Birth: Country of Birth:	Aboriginal Yes/No Torres Strait Islander Yes/No	Special cultural/spiritual/religious needs of the person	
Medicare Number:	Person number on card	Expiry	

Flying Changes Development Coaching

Comprehensive Client Support Documentation

Pause Feel Breathe Reflect Choose

NDIS Number	NDIS plan dates	NDIS line items	
Pension Type	Pension Number	Expiry date	
Emergency Contact:	Relationship to participant	Mobile:	
Does participant have Legal Guardian:	Phone:	Is the person in Voluntary Out of Home Care?	Is the person in Statutory Out of Home Care?
Does the participant have a Case-Plan?	Caseworker:	Organisation:	Contact Details: Phone: Email:
Does the participant have a NDIS Support Co-ordinator? Yes/No	Name	Organisation	Contact Details: Phone: Email:
Does the person attend/participate in school, vocational activities? Yes/No	Name of Centre	Contact person	Contact Details: Phone: Email: Details of attendance:
Does the person attend/participate regularly in social and leisure activities? Yes/No	Venue:	Contact person	Contact Details: Phone: Email: Details of attendance:

Medical and support needs Information

Please give detailed information to enable Flying Changes Development Coaching to provide required support.

Please attach additional information if there is not enough space available on form and additional documentations or plans of support.

Support Required	Yes	No	If YES - Provide Details / What Assistance / Support Is Needed
Does the person have a disability?			
Does the person have any cognitive or developmental issues?			
Does the person suffer from any medical conditions such as Epilepsy? Asthma? Diabetes?			
Has the young person had a tetanus shot?			If so, When?
Special communication or language needs of the person			If yes provide details
Does the person have any mobility issues?			If so, describe and attach any mobility plans that are available

Does the person have any special dietary requirements?			If yes provide/attach Dietary Plan
Does the person have any allergies?			If yes provide/attach Allergy Plan
Does the person have any behavioural difficulties?			Details
Is there a BSP, BMP, or IPRP available?			Please provide / attach all Behaviour Plans or IPRP's
Does the person have any safety risks?			If yes please provide details or any completed risk assessments or plans
Can the person swim 25 metres?			
Are there any special requirements regarding Transportation?			If yes, please describe.
Describe the likes and interests of the child or young person			Details
Does the person have difficulty sleeping or is awake during the night			If yes, please describe sleeping routines
Is assistance with Showering / Bathing required?			If yes, please describe assistance required.

Is assistance with Dressing required?			If yes, please describe assistance required.
Is assistance with Eating required?			If yes, please describe assistance required.
Is assistance with Toileting required?			If yes, please describe assistance required.
Is assistance with Menstruation required?			If yes, please describe assistance required.
Does the person require support for living skills			If yes, please describe.
Does the person require support for socialisation Describe the likes and interests of the child or young person			If yes, please describe and attach any relevant plans.
Are there any other requirements that we need to know of to support this person?			If yes, please describe.
Is there known fears or allergies that may be relevant around farm animals? Eg. Fear of birds, mice, dogs….. Reactions to Mozzies, mud, sun screen			

Current Medication

Please note: All medication must be supplied in a Chemist Packed individual dose labeled portions eg. Webster pack and given to the Support Worker when the young person is dropped off.

Does the participant take any current medication? Yes/No

Do they self administer/manage their medication? Yes/No

If yes please fill in details below:

Name of Medication	Breakfast		Lunch		Before Bed	
	Time	Dosage	Time	Dosage	Time	Dosage

Authority to administer medication:

I give consent for a Support Worker to administer medication to:_____

Name: **Relationship:**

Flying Changes Development Coaching Service Agreement

I _____ have completed agreement_____

(Insert Person Responsible i.e. Parent or Carer) *(Insert Person's Name)*

to attend the Services _____

(service requested by FCDC)

The total cost for this service is as per service agreement if complex service agreement forms with full schedule of supports:

If a one off such as camp the total amount $_____(Must be completed)

(cost of service requested)

I understand that the participant may be engaging in a range of activities within the farm and community.

_____ Date ____/_____/_____.

(Signature)

SERVICE COSTS

Invoice will be provided to plan management fund direct if required.

Payment is required as per terms of service agreement.

All cancellations of camps with less than 5 business days notice will incur a 90% cancellation fee as per NDIS guidelines.

Please make all payments to Flying Changes Development Coaching (ABN) 39 985 818 098

- Electronic transfer to ING **BSB: 923 100 Acct No: 305382530**
- Include an invoice number on remittance and email to: Michelle@flyingchangesdc.com.au