Aged Care - Participant Intake Form

Participant Information

First Name			**Surname**		
Street Address				**Post code**	
Phone/TTY		**Mobile**		**Email**	
Date of Birth		**Gender**		**#**	

Main CONTACT

Name			**Relationship**		
Street Address				**Post code**	
Phone/TTY		**Mobile**		**Email**	

FUNDING DETAILS

Service Delivery Dates (dates the practitioner will begin/end delivering services)	Start Date		End Date	
Fund Management (for the funding category we will be accessing)	**Self-Managed**	**Agency Managed**	**Home Care Package**	**Residential Care**
Invoices to be sent to: (email)				

SUMMARY OF SERVICES TO BE PROVIDED – Will be discussed and quoted with Service Agreement

Improved Relationships	**Price**
11_022_0110_7_3 Specialist Behavioural Intervention Support	$193.99 per hour
11_023_0110_7_3 Behaviour management plan, training in behaviour management strategies	$193.99 per hour

CONSENT TO SHARE

List other organisations/individuals involved:

Completed by _____ **Date:** _____

Service Plan Information

Date Service Plan developed:	
Date Service Plan to be reviewed:	
Completed by (name):	
Practitioner/s (name):	
Individuals consulted in Service Plan development:	

CULTURAL BACKGROUND AND PREFERENCES

Aboriginal or Torres Strait Islander Origin?	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander
CALD Status	
Preferred language	
Interpreter Required	

DIAGNOSES/HEALTH

Primary Disability	☐ ADHD ☐ Acquired Brain Injury ☐ Autism Spectrum Disorder ☐ Blind/Vision Impairment ☐ Cerebral Palsy ☐ Deaf/Hearing Impairment ☐ Developmental Delay ☐ Multiple Sclerosis	☐ Neurological ☐ Psychosocial Disability ☐ Speech Impairment ☐ Dementia ☐ Stroke ☐ Intellectual Disability ☐ Down Syndrome ☐ Other Specify:
Communication Method	☐ Verbal ☐ Non-verbal ☐ Sign language - Auslan or Makaton ☐ Key Word Sign ☐ Point/gesture ☐ Augmentative and Alternative Communication (AAC)	

Any ongoing health issues?

E.g., Mobility, Epilepsy

SUPPORTS		
How will supports be provided? Face to Face, Telehealth and correspondence via Email and phone.		
Participant likes/dislikes/strengths		
Goals of support		
Has a home safety checklist been completed?	☐ Yes ☐ No	Comments:

Does the participant have a current Positive Behaviour Support Plan?	☐ Yes ☐ No	Comments:
Does the participant have a current risk assessment relating to their behaviour or support needs?	☐ Yes ☐ No	Comments:

Additional Info
List of behaviours of concern:
List of restrictive practices: