**Support Work Service Agreement**

**PARTICIPANT DETAILS**

First Name: ………………………………………………………………………………………………………

Surname: ………………….……………………………………………………………………………………..

Preferred Name: ………………………………………………………………………………………………..

Date Of Birth: ……. /……./…….

Gender: Male Female Other

If other, please indicate preferred pronouns: ……………………………………………………………

Aboriginal Torres Strait Islander Both Aboriginal & TSI Neither Aboriginal/TSI

Are there any cultural considerations to be aware of? YES NO If yes please provide details: ………………………………………………………………………………………………………………………

Address: ………………………………………………………………………………………………………….

Suburb: …………………………………………………………………………………………………………..

State: …………………………………………….. Postcode: ………………………………………............

Phone

Mobile: …………………………………………… Home: …………………………………………………….

Email: ……………………………………………………………………………………………………………..

**FAMILY**

Name of Siblings: ………………………………………………………………………………………………

Ages of Siblings: ………………………………………………………………………………………………..

Household Members: ………………………………………………………………………………………….

Living Arrangements: Both Parents Shared Care Other

If Other please specify: ………………………………………………………………………………………..

**ARE THERE ANY COURT ORDERS? IF SO, PLEASE PROVIDE DETAILS BELOW….**

|  |
| --- |
|  |

**PARENT/GUARDIAN DETAILS**

**Parent/Guardian #1:**

First Name: ………………………………………………………………………………………………………

Surname: …………………………………………………………………………………………………………

Relationship to Participant: ………………………………………………………………………………….

Address: ………………………………………………………………………………………………………….

Suburb: …………………………………………………………………………………………………………..

State: ……………………………………………… Postcode: ………………………………………………..

Phone

Mobile: ………………………………………. Home: …………………………………………………………

Work: ……………………………………………………………………………………………………………..

Email: ……………………………………………………………………………………………………………..

**Parent/Guardian #2:**

First Name: ………………………………………………………………………………………………………

Surname: …………………………………………………………………………………………………………

Relationship to Participant: ………………………………………………………………………………….

Address: ………………………………………………………………………………………………………….

Suburb: …………………………………………………………………………………………………………..

State: ………………………………………………. Postcode: ……………………………………………….

Phone

Mobile: ………………………………………………. Home: …………………………………………………

Work: ……………………………………………………………………………………………………………..

Email: ……………………………………………………………………………………………………………..

**EMERGENCY CONTACTS**

**(PLEASE NOMINATE TWO ALTERNATIVE CONTACTS OTHER THAN THE PARENT/GUARDIANS)**

**EMERGENCY CONTACT #1**

First Name: ………………………………………………………………………………………………………

Surname: …………………………………………………………………………………………………………

Relationship to Participant: ………………………………………………………………………………….

Address: ………………………………………………………………………………………………………….

Suburb: …………………………………………………………………………………………………………..

State: …………………………………………………. Postcode: …………………………………………….

Phone

Mobile: ………………………………………………. Home: …………………………………………………

**EMERGENCY CONTACT #2**

First Name: ………………………………………………………………………………………………………

Surname: …………………………………………………………………………………………………………

Relationship to Participant: ………………………………………………………………………………….

Address: ………………………………………………………………………………………………………….

Suburb: …………………………………………………………………………………………………………..

State: …………………………………………………. Postcode: …………………………………………….

Phone

Mobile: ………………………………………………. Home: …………………………………………………

**MEDICAL INFORMATION**

Is the participant currently on any medication? YES NO

If yes, please list current medications they are taking:

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **DOSAGE** | **FREQUENCY** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Does the participant have any allergies? YES NO

If yes, please list: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Does the participant suffer with Asthma? YES NO

If yes, do they have a current Asthma plan? YES NO **(If yes, please provide a current Asthma plan provided by the participant’s medical professional)**

Does the participant have any pre-existing medical conditions? YES NO If yes, please detail: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**MEDICARE**

Medicare Number: ……………………………………Expiry Date: ……………………………………….

Participant’s Reference Number: ……………………………………………………………………………

General Practitioner’s Name: ………………………………………………………………………………..

Phone Number: …………………………………………………………………………………………………

Address: ………………………………………………………………………………………………………….

Does the participant have Ambulance Cover? YES NO If yes, please provide Ambulance Membership Number: …………………………………………………………………………………………

If NO, do you authorise staff to call an ambulance if necessary for the participant?

YES NO

**In case of emergency, I understand that every effort will be made to contact me, or the contact people listed above. If I cannot be reached, I understand that staff will use a standard 000 protocol and have my child taken to the nearest hospital.**

**This information is to assist medical staff in the event of an emergency, all information will be kept confidential unless being handed to ambulance or medical staff. This form will only be shared with emergency staff in the event of an emergency.**

**SIGNATURE OF PARENT/GUARDIAN: DATE:**

**………………………………………………………………… ………………………………..**

**DAILY CARE NEEDS**

Does the participant toilet independently? YES No Please explain any assistance required including any prompts used: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Does the participant dress themselves independently? YES NO

Does the participant eat independently? YES No

**COMMUNICATION LEVEL**

**(Please tick all that apply to the participant)**

 Is verbal

 Is nonverbal

 Uses an augmentative communication system/device (please specify): ………………………………………………………………………………………………………………………

 Follows verbal/nonverbal directions

 Indicates their likes and dislikes

 Makes requests for their basic wants and needs

**CHALLENGING BEHAVIOURS**

**(Please tick all that apply to the participant and describe as needed)**

**THE PARTICIPANT MAY:**

 Run away

 Act aggressively towards self/others: ………………………………………………………………………………………………………………………

 Shut down/withdraw

 Be non-compliant

 Inappropriately touch self/others

 Is self-injurious: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

 Other: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Please list any strategies that assist in calming the participant when they become overwhelmed or if a meltdown was to occur during support: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**SENSORY**

**(Please tick all that apply to the participant)**

The participant:

 Avoids or seeks touch from others (please circle which is applicable)

 Avoids or seeks messy play such as playdoh, glue and paint (please circle which applies)

 Plays rough in play/leisure activities

 Avoids participation in sports or active games

 Craves or avoids movement (please circle which applies)

 Seems to be in constant motion (loves spinning, swinging, being upside down)

 Cannot process or tolerate extremes of intensity such as colour, light, etc. Please describe: ………………………………………………………………………………………………………………………

 Is over or under sensitive to sounds (please circle which one applies)

 Eats non-edible items

 Dislikes strong smells/tastes

**ACTIVITIES OF DAILY LIVING**

**(Please tick all that apply to the participant)**

**THE PARTICIPANT IS NOT YET INDEPENDENT IN THE FOLLOWI8NG AREAS:**

 Dressing/Bathing Shopping Eating

 Daily Chores Walking Money Management

 Toileting Hygiene Telephone/Transportation

 Food Preparation/Medications

**PLEASE LIST THE GOALS/SKILLS THAT YOU WOULD LIKE TO SEE THE PARTICIPANT IMPROVE UPON THROUGH PARTICIPATION IN A SOCIAL SKILLS PROGRAM:**

**………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**

**NDIS PLAN**

Does the participant have an approved NDIS Plan: YES NO If yes, please complete the following:

NDIS number: …………………………………………………………………………………………………..

Start date of the NDIS Plan: …………………………………………………………………………………

End date of the NDIS Plan: …………………………………………………………………………………..

Please tick the box that describes your NDIS Plan:

 Self-managed

 Plan-managed (you have engaged someone to manage your invoices & payments of services)

 NDIA-managed (Agency-managed)

**PLAN MANAGER**

**If your NDIS plan is plan managed, please provide the following details:**

Name of Plan Management Organisation: ………………………………………………………………………………………………………………………

Plan manager’s name: ………………………………………………………………………………………...

Email: ……………………………………………………………………………………………………………..

Phone: …………………………………………………………………………………………………………….

**SUPPORT COORDINATOR**

**If you have a support coordinator, please provide the following details:**

Support Coordinator (Organisation): ………………………………………………………………………

Support Coordinator (Contact Name): …………………………………………………………………….

Email: ……………………………………………………………………………………………………………..

Phone: …………………………………………………………………………………………………………….

**Please provide the goals as outlined in your NDIS Plan:**

GOAL (1): ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

GOAL (2): ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

GOAL (3): ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Description Of Support**

|  |  |  |  |
| --- | --- | --- | --- |
| **SUPPORT** | **DESCRIPTION OF SUPPORT****List the details of the support including scope and volume.** | **PRICE & PAYMENT INFORMATION** | **PLANNED ROSTER ACROSS A WEEK** |
| **Assistance with Self-Care Activities – Standard – Weekday Daytime – 01\_011\_0107\_1\_1** | **Discuss together with the support worker what are the expectations** | **$67.56 per hour** | **E.g.** **Monday – 2 hours****Tuesday – 2 hours****= 4 hours per week - $27.24/per week** |
| **Assistance with Self-Care Activities – Standard – Weekday Evening – 01\_015\_0107\_1\_1** | **Discuss together with the support worker what are the expectations** | **$74.44 per hour** | **E.g.****Monday – 3 hours****Tuesday – 2 hours****= 5 hours per week - $372.20** |
| **Assistance with Self-Care Activities – Standard Public Holiday – 01\_012\_0107\_1\_1** | **Discuss together with the support worker what are the expectations** | **$150.10 per hour** | **E.g.****Monday – 5 hours****Friday – 3 hours****= 8 hours per two public holidays - $1200.80** |
| **Assistance with Self-Care Activities – Standard Saturday – 01\_013\_0107\_1\_1** | **Discuss together with the support worker what are the expectations** | **$95.07 per hour** | **E.g.****Saturday – 3 hours****= 3 hours per week - $285.21** |
| **Assistance with Self-Care Activities – Standard Sunday – 01\_014\_0107\_1\_1** | **Discuss together with the support worker what are the expectations** | **$122.59 per hour** | **E.g.****Sunday – 5 hours per week** **= $612.95** |
| **TOTAL COSTING FOR SUPPORTS**  |  |  |  |

**CONSENT FOR USE OF INFORMATION, PRIVACY, PHOTOS/VIDEOS ETC…**

**PLEASE READ CAREFULLY**

Thank you for completing the form, the more information you provide about the participant the more that we have to work with to help encourage the participant to achieve their best outcomes. Please keep us informed of any changes to ensure our records are up to date regarding any details/changes that may affect the participant.

The undersigned agrees and acknowledges that they have read and agree to the following conditions. All information collected with the staff at Eb’s Rainbow who will be working together to develop an individualised program for the participant as well as other authorised professionals nominated by you. Any information shared will be on a professional basis only and be required for the delivery of services. All reasonable steps are taken to keep your personal information confidential, and your details will not be used for marketing or any other purposes without your permission.

From time to time, we may video or photograph the participant, and these may be used with discretion on our website or social media platforms. Please inform the staff and note below if you do not want the participant to be recorded or photographed during the social skills groups, or any other activities. Special occasions for example Christmas Party. End of term events.

Although all reasonable steps are taken to protect and keep your child safe no Eb’s Rainbow staff or helpers can be held liable for any injury to your child or any carer in attendance at any venue whether that be negligent or innocent in nature. No guarantees are made as to the outcomes of services and no member of the organisation can he held liable in any way. All members of Eb’s Rainbow reserve the right to refuse to give service if there is abuse of any kind toward a staff member, another participant or any person associated with our services. If any person fears for their safety or for any other reason which need or be disclosed.

Parent/Guardian Name: ……………………………………………………………………………………..

Signature: ……………………………………………………………………………………………………….

Date: ………………………………………………………………………………………………………………

I (Parent/Guardian Name): ………………………………………………………………………………….

Hereby GIVE DO NOT consent to Eb’s Rainbow to take photos/videos of the participant, (Participant’s Name): ………………………………………………………………………………………….

I understand that the participant’s name will not be attached to any photos/videos that are uploaded and that I have the right to withdraw this consent at any time.

Parent/Guardian Name: ……………………………………………………………………………………..

Signature: ………………………………………………………………………………………………………..

Date: ………………………………………………………………………………………………………………

**TERMS AND CONDITIONS**

**Participant/Parent/Guardian is responsible for:**

* Managing appointments
* All entry costs or extracurricular fees within the community. If there is a companion card, please ensure it is sent each session.
* Being polite and respectful to staff who work with you.
* Advising Eb’s Rainbow of any problems.
* Contacting Eb’s Rainbow if you can’t make it to a session – you are required to provide at least 48 hours business notice.
* Advising Eb’s Rainbow if you want to end an agreement.

**Cancellation of scheduled appointments or missed sessions:**

* You are required to provide at least 24 hours business notice if you cannot attend a session.
* All sessions missed will be charged at the appropriate program rate.

**Service Provider is responsible for:**

* Providing services that the Participant or Parent/Guardian has asked for.
* Being open and honest about the work that Eb’s Rainbow does and explaining things clearly.
* Treating the Participant and the Parent/Guardian politely and with respect.
* Including the Participant and Parent/Guardian in all the decisions about the supports that Eb’s Rainbow provides.
* Advising the Participant and the Parent/Guardian if Eb’s Rainbow wishes to end the agreement.
* Ensuring the Participant’s information is correct, up to date and stored privately.
* Providing invoices and statements for your supports.
* Checking that the agreement is working well.

**Making changes to this agreement:**

* Changes requested by the Participant and Parent/Guardian must be submitted in writing to Eb’s Rainbow at info@ebsrainbow.com.au
* Changes recommended by Eb’s Rainbow will be submitted to the Participant and Parent/Guardian via their personal email address.
* The Participant, Parent/Guardian and Eb’s Rainbow must all agree to the requested changes.
* A Service Agreement Amendment document will need to be signed.
* Fees are subject to increase without notice in line with activities that the Participant participates in.

**Ending the Agreement:**

* A notice period of **2 weeks** is required by either party in writing.
* An agreement may end without a notice period if either party breaks the Agreement in some way (e.g.: participant is not attending appointments and cannot be contacted; provider is always late which is impacting on other schedules, etc.)
* Inappropriate behaviour/Abusive behaviours.

**What to do if there is a problem or you wish to lodge a complaint:**

**Contact Eb’s Rainbow:**

Phone: 0475 431 543

Email: info@ebsrainbow.com.au

Address: 114 Yarana Drive, Mount Helen 3350.

**AGREEMENT SIGNATURES:**

The parties agree to the terms and conditions of this Service Agreement. I understand that all information is confidential and will only be used to assist in the delivery of planned support services.

**Signature Parent/Guardian: Name of Parent/Guardian: Date:**

**……………………………………………. ……………………………………….. …………….**

**Signature of authorised person from Name of authorised person from Date:**

**Eb’s Rainbow: Eb’s Rainbow:**

**…………………………………………………… …………………………………………… …………….**