**Please email this completed form to** [**ndis@accesshc.org.au**](mailto:ndis@accesshc.org.au)

**DATE:** Click or tap here to enter text.

**PROVIDER:** Access Health & Community, 283 Church Street, Richmond, VIC, 3121, Australia. Ph. 9810 3000

Current Child & Family Service site locations:

|  |  |  |  |
| --- | --- | --- | --- |
| * Lower Templestowe | * North Balwyn (Opening July 2018) | * Box Hill | * Ashburton |

*We are able to provide services in the context most appropriate (incl. home, school/kinder, childcare, clinic, etc..). Working with children aged 0-12yrs.*

**PARTICIPANT DETAILS:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Click here to enter text. | | | |
| Date of birth | Click here to enter a date. | | NDIS number | Click here to enter text. |
| Contact Name & Number | Click here to enter text.  Click here to enter text. | | Email address | Click here to enter text. |
| NDIS Plan start date | Click here to enter a date. | | NDIS Plan end date | Click here to enter a date. |
| Alternative Contact Name & Number (if approp.) | | Click here to enter text.  Click here to enter text. | | |

|  |  |
| --- | --- |
| **Service Request Details** | |
| Service: | Click or tap here to enter text. |
| Preferred Day: | Click or tap here to enter text. |
| Preferred Time: | Click or tap here to enter text. |
| Preferred Location: | Click or tap here to enter text. |
| Other/Preference: | Click or tap here to enter text. |
| Access HC to provide a copy of the **Service Agreement** and Statement of Service/**Schedule of Supports** to participant and Support Coordinator, where appropriate. | |

|  |
| --- |
| I wish to refer the above NDIS participant to your organisation for: |
|  |

|  |
| --- |
| **NDIS PLAN GOALS relevant to AccessHC** |
| Please include participants NDIS goals |

**PAYMENT:**

Participant has chosen the following payment method (Please tick chosen method):

**The National Disability Insurance Agency**

**Plan Management Provider**

Office Address: Click or tap here to enter text.

ABN: Click or tap here to enter text.

Email: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

**Participant is self-managing funding.**

Email: Click or tap here to enter text.

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | | | |
| Name: |  | Relationship: | Click or tap here to enter text. |
| Phone: | Click or tap here to enter text. | Email: | Click or tap here to enter text. |
| Referrer requests: | Copy of Service Agreement and Statement of Service/Schedule of Supports (with participant consent) | | |