|  |  |  |
| --- | --- | --- |
| **Referral Date:** |  | |
| **Title:** | Miss:  Mrs:  Ms:  Mr:  Other: ……………………… | |
| **First Name:** |  | |
| **Last Name:** |  | |
| **DOB:** |  | |
| **Gender:** | Female Male Non-Binary/Gender Fluid Other:………………………. | |
| **Identifies as:** | Aboriginal Torres Strait Islander  Aboriginal & Torres Strait Islander Neither | |
| **Address:** |  | |
| **Participant Contact Details:** | **Phone:**  **Email:** | |
| **Alternate Contact:** | **Name & Relationship:** | **Phone number:**  **Email:** |
| **NDIS Number:** |  | |
| **Disability (if known):** |  | |
| **Medical Conditions (if applicable):** |  | |
| **Reason for referral:** | Support Coordination  Day Program Tuesday  Day Program Thursday  Sunday Community Outing  Housing -  - Supported Independent Living (SIL)  - Short Term Accommodation (STA)/Respite | |
| **Details of referral:** |  | |
| **Background/History (relevant to referral):** |  | |
| **Participant/NDIS goals:** |  | |
| **Support Area and allocated funds:** |  | |
| **Supports paid for by:** | - NDIA Managed  - Plan Manager:……………………………………………………  - Self Managed | |
| **Additional information:** |  | |
| Please send all referrals to: shae.bss@outlook.com to be delegated to the relevant team member.  If you require any assistance in completing this form, or wish to speak to someone before submission, please call our office on 0411 963 244. | | |

# Ballarat Support Services – Incoming Referral Form