BALLARAT SUPPORT SERVICES

Participant Intake Form

Please complete every section. If a question doesn't apply, mark it N/A. An intake officer will review this form with you before services begin.

1 Participant Details

Participant Name		**D.O.B**	
NDIS Number		**Gender**	
Plan Dates	**Start Date:** **End Date:**		
Phone Number	**Home:** **Mobile:**		
Email Address			
Residential Address			
Language spoken at home		**Interpreter required**	☐ Yes ☐ No
Preferred contact method	☐ Email ☐ Post ☐ Phone ☐ Comms device		
Aboriginal or Torres Strait Islander	☐ Yes ☐ No		

Can the participant sign on their own behalf? ☐ Yes ☐ No

Person signing on the participant's behalf (if required)	
Name	
Relationship to participant	☐ Parent ☐ Guardian ☐ Caregiver ☐ Other: _____
Phone Number	**Home:** **Mobile:**
Email Address	
Is this person the emergency contact?	☐ Yes ☐ No — if no, complete Emergency Contact below

Emergency contact	
Name	
Relationship to participant	☐ Parent ☐ Guardian ☐ Caregiver ☐ Other: _____
Phone Number	**Home:** **Mobile:**
Email Address	

Is there a Guardianship or Administration Order in place? ☐ Yes ☐ No

Guardian / Administrator

Name	
Phone Number	
Email Address	

Does the participant have a Support Coordinator? ☐ Yes ☐ No

Support Coordinator	
Name	
Phone Number	
Email Address	

2 Disability, Medical Conditions & Allergies

Please list all diagnoses, medical conditions, and allergies	
1.	
2.	
3.	
4.	
5.	

Please tick any that apply and attach the relevant documentation
☐ Current Medication List (from GP / Pharmacist)
☐ Asthma Plan / COPD Plan
☐ Diabetes Management Plan
☐ Anaphylaxis Plan
☐ Behaviour Support Plan
☐ Epilepsy Management Plan
☐ Other: _____

Behaviours of concern / risk

Check any relevant boxes and attach supporting information or a Behaviour Support Plan where available.

Behaviours of Concern	History / Current	Yes / No
Verbal aggression to staff or other clients	☐ H ☐ C	☐ Yes ☐ No
Physical aggression to staff or other clients	☐ H ☐ C	☐ Yes ☐ No
Property damage	☐ H ☐ C	☐ Yes ☐ No
Threats of harm to staff or other clients	☐ H ☐ C	☐ Yes ☐ No
Self-harm or threats of self-harm	☐ H ☐ C	☐ Yes ☐ No
Substance use (drugs, alcohol, etc.)	☐ H ☐ C	☐ Yes ☐ No
Sexual abuse	☐ H ☐ C	☐ Yes ☐ No
Absconding	☐ H ☐ C	☐ Yes ☐ No
Other: _____	☐ H ☐ C	☐ Yes ☐ No

3 Risk Assessment

Check any relevant boxes and attach supporting information or reports where applicable.

Risk	Yes	No	Comments
Communication			
Hearing OK	☐	☐	
Speech OK	☐	☐	
Can read	☐	☐	
Can write	☐	☐	
Cognition			
Oriented to time and place	☐	☐	
Able to participate in self-care	☐	☐	
Able to accept direction / instruction	☐	☐	
Short-term memory issues	☐	☐	
Mobility & Manual Handling			
Walks unaided	☐	☐	
Manages stairs unaided	☐	☐	
Uses a walking aid (4WW, stick, etc.)	☐	☐	
Uses a wheelchair	☐	☐	
Manual handling equipment in place and used	☐	☐	
Personal Care Assistance			
Toileting	☐	☐	
Eating / drinking — swallowing or choking risk	☐	☐	
Changing — assistance before/after swimming	☐	☐	

4 Medication

Do you take medication? ☐ Yes ☐ No *— If yes, provide details below and attach a medication list.*

Medication 1	
Medication 2	
Medication 3	

5 Health Care Information

Medicare Number		**Expiry Date**	
Medicare Ref No.			
Private Healthcare Provider		**Membership No.**	
Provider Ref No.			
Doctor's Name			
Doctor's Clinic			
Clinic Address			
Clinic Phone			

6 NDIS Funding

Enter details below or attach a copy of the NDIS plan.

Budget	Management type	Amount
Core budget	☐ NDIA Managed (PRODA) ☐ Plan Managed — Plan Manager: _____ ☐ Self-Managed	NDIA: $_____ Plan: $_____ Self: $_____
Transport budget	☐ NDIA Managed ☐ Plan Managed — Plan Manager: _____ ☐ Self-Managed	Budget: $_____

Billing details (for invoices)	
Name	
Email	
Phone	
Comments	

7 Other service providers currently in place

Provider 1	
Name	
Address	
Phone number	
Email	
Frequency of use	

Provider 2	
Name	
Address	
Phone number	
Email	
Frequency of use	

If there are more than two other providers, attach a list to this form.

8 Preferences

Preferred name	
Religious requirements	
Cultural requirements	
Other considerations	
Preferred days of attendance	

9 Goals and Aspirations

What do you want to achieve — life skills, physical, social, other?	
Immediately	
In 6 months	
In 12 months	

10 Days of Support / Times

Day	Start time	End time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

11 Other information

Is there any other information you'd like staff to know to support you best?

Declaration & Signature

Preferred method for completing forms and agreements:

☐ DocuSign (our preferred online method) Email: _____

☐ In person

Declaration

I understand that:

- These documents are owned by Ballarat Support Services.
- Information within these records will be shared with other staff within the organisation only when staff require the information to carry out their duties.
- I can request to see my records and receive a copy.
- Records are archived for a set period in accordance with BSS policy and procedure.
- All information obtained will be kept confidential.
- To the best of my knowledge, the information provided in this form is true and correct.

Name (Participant or Guardian)	Date
Signature	