Therapy inc

Application for Services

Section A: Participant Information (the participant is the person who will be receiving services)			
First Name:		Last Name:	
Preferred Name:			
Date of Birth:		Gender:	☐ Male ☐ Female ☐ Unspecified
Is the participant Aboriginal or Torres Strait Islander?		☐ Aboriginal ☐ Torres Strait Islander ☐ Aboriginal & Torres Strait Islander ☐ Neither	
Residential Address:			
Suburb:		Postcode:	
Language Spoken:			
Interpreter required:		☐ Yes ☐ No	

Participant contact details			
Is the participant the main contact for this application and during service delivery?			
☐ Yes – Please provide your contact details below		☐ No – Please complete contact details in ***Section B & C*** with the contact details of your authorised representative	
Postal Address:			☐ Same as participant
Suburb:		Postcode:	
Home phone:		Mobile:	
Email address:			
Preferred contact method:	☐ Phone ☐ Mobile ☐ Email ☐ Post		

Therapy inc

Section B: Contact information			
Main Contact (the main contact is the person we will contact about the application and services, if this is different to the participant)			
First Name:		Last Name:	
Preferred Name:			
Relationship to Participant:			
Date of Birth:		Gender:	☐ Male ☐ Female ☐ Unspecified
Residential Address:			☐ Same as participant
Suburb:		Postcode:	
Postal Address:			☐ Same as participant
Suburb:		Postcode:	
Home phone:		Mobile:	
Email address:			
Language Spoken:			
Interpreter required:		☐ Yes ☐ No	
Preferred contact method:	☐ Phone ☐ Mobile ☐ Email ☐ Post		

Section C: Alternative Contact information			
Alternative Contact (the alternative contact is the person we will contact if we are unable to get in contact with the applicant/main contact)			
First Name:		Last Name:	
Preferred Name:			
Relationship to Participant:			
Date of Birth:		Gender:	☐ Male ☐ Female ☐ Unspecified
Residential Address:			☐ Same as participant

Suburb:		Postcode:	
Postal Address:			☐ Same as participant
Suburb:		Postcode:	
Home phone:		Mobile:	
Email address:			
Language Spoken:			
Interpreter required:		☐ Yes ☐ No	
Preferred contact method:	☐ Phone ☐ Mobile ☐ Email ☐ Post		

Section D: Next of Kin Contact information			
Next of Kin (the next of kin is the person we will contact in an emergency)			
☐ ***Same as main contact*** (if your next of kin is the same as your main contact, continue to section E)		☐ ***Same as alternative contact*** (if your next of kin is the same as your alternate contact, continue to section E)	
First Name:		Last Name:	
Preferred Name:			
Relationship to Participant:			
Date of Birth:		Gender:	☐ Male ☐ Female ☐ Unspecified
Residential Address:			☐ Same as participant
Suburb:		Postcode:	
Postal Address:			☐ Same as participant
Suburb:		Postcode:	
Home phone:		Mobile:	
Email address:			
Language Spoken:			
Interpreter required:		☐ Yes ☐ No	
Preferred contact method:	☐ Phone ☐ Mobile ☐ Email ☐ Post		

Therapy inc

Section E: Legal Guardianship

Has a legal guardian been appointed for the participant?

☐ No – Proceed to ***Section F***

☐ Yes – Please select which one of the following orders are in place:

☐ Administration

☐ Power of Attorney

☐ Enduring Power of Attorney

☐ Family Court Order

Is the main contact the legal guardian?

☐ Yes – Proceed to ***Section F***

☐ No – Please provide details below

First Name:		Last Name:	
Agency:			
Postal Address:			
Suburb:		Postcode:	
Phone:		Mobile:	
Email address:			
Language Spoken:			
Interpreter required:		☐ Yes ☐ No	
Preferred contact method:	☐ Phone ☐ Mobile ☐ Email ☐ Post		

Please provide any necessary supporting documentation to assist with the processing of the application for services.

Section F: Funding

☐ NDIS – please note that a copy of your NDIS plan is required for NDIA managed participants

NDIS Number:	
NDIS plan dates:	

☐ Privately funded ☐ Helping Children with Autism (HCWA)
☐ Chronic Disease Management Plan (CDM)

Section G: Disability/Diagnoses	
Please indicate what the participant's primary diagnosis is: (please select all relevant diagnoses)	
☐ Acquired Brain Injury ☐ Autism Spectrum Disorder (ASD) ☐ Cerebral Palsy GMFCS level: ☐ Deaf Blind (dual sensory) ☐ Down Syndrome ☐ Developmental Delay (DD) ☐ Epilepsy ☐ Global Developmental Delay (GDD) ☐ Hearing Impairment ☐ Intellectual Disability ☐ Motor Neurone Disease ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Para/Quadri(Tetra)/Hemiplegia ☐ Psychosocial Disability ☐ Spina Bifida ☐ Stroke ☐ Vision Impairment	
Other (please specify):	
Please provide any supporting documentation to assist with the processing of the application for services.	

Therapy inc

Section H: Health related concerns	
Please indicate whether the participant has previously or is currently experiencing any of the following: (please select all relevant options)	
☐ Anxiety or other mental health concerns ☐ Aspiration (gagging, choking or recurrent chest infections) ☐ Difficulty swallowing during mealtimes (dysphagia) ☐ Pressure ulcers ☐ Recurrent falls ☐ Self-harming or risk seeking behaviour ☐ Significant pain or discomfort ☐ Tracheostomy ☐ Upcoming planned surgery (within the next 6 months) ☐ Recent surgery (in the last 6 months) ☐ Seizures ☐ Difficulty eating a variety of foods ☐ Difficulty falling/remaining asleep ☐ Urinary catheter or stoma	
Other (please specify):	
Please provide any supporting documentation to assist with the processing of the application for services.	

Therapy inc

Section I: Requested Supports/Services	
Please indicate below what services you require:	
Service:	Reason/goal:
☐ Occupational Therapy	
☐ Physiotherapy	
☐ Speech Pathology	
☐ Psychology	
Does the participant use/require any assistive technology? ☐ Yes – please provide details below ☐ No ☐ Unsure	

Section J: Locations for Services (Service locations refers to the locations you would like for services to occur)		
Where would you like for services to occur (multiple locations may be selected)?		
☐ Home	Address:	
☐ School	Address:	
☐ Daycare/Playgroup	Address:	
☐ Clinic	Address:	
☐ Community	Address:	
☐ Work	Address:	

Section K: Consents		
Please indicate below which (if any) key stakeholders you consent for Therapy Inclusive staff to liaise with regarding your application:		
Key Stakeholder:	Contact details:	
☐ Local Area Coordinator/LAC (please note that you will need to provide	Agency Name:	
	Contact Name:	

consent to your LAC directly prior to us being able to contact them)	Phone:	
	Email:	
☐ School	School:	
	Contact Name:	
	Phone:	
	Email:	
☐ Daycare/Playgroup	Agency Name:	
	Contact Name:	
	Phone:	
	Email:	
☐ Support Coordinator	Agency Name:	
	Contact Name:	
	Phone:	
	Email:	
☐ Service Provider	Agency Name:	
	Contact Name:	
	Phone:	
	Email:	
☐ GP/Medical Specialist	Agency Name:	
	Contact Name:	
	Phone:	

	Email:	
☐ Other	Agency Name:	
	Contact Name:	
	Phone:	
	Email:	
☐ Other	Agency Name:	
	Contact Name:	
	Phone:	
	Email:	

- These records are owned by Therapy Inclusive.
- Information within these records will be shared with other staff within the organisation only when staff require the information to carry out their duties.
- You can ask to see records and receive a copy of this application form.
- Records are archived for a set period according to policy and procedure.
- All information obtained will be kept confidential.

☐ To the best of your knowledge, the information provided in this form is true and correct

Signature:	
Participant/Authorised Representative Name:	
Date:	

Please submit the completed form to **info@therapyinc.com.au,** alternatively you can return the completed form to us in person at our Cockburn Central clinic **U6, Cockburn Gateway Shopping Centre, 816 Beeliar Drive, Cockburn Central.**

Therapy inc

Storage, Access, and Correction of Personal Information:

All Disability Professional Service Providers are bound by the Privacy Act 1988. As such, Therapy Focus undertakes to adhere to the Australian Privacy Principles, which regulate how we may collect, use, disclose and store personal information and how individuals may access and correct personal information held about them. For more information about how privacy is managed at, please visit our website at www.therapyinc.com.au.au or contact us by phone or email.

Note:

If you require assistance completing this application form, please contact us by phone, email us at: info@therapyinc.com.au or attend the clinic for support.