

## PARTICIPANT SDA INTAKE FORM

### Participant Details

<b>Participant Name</b>		<b>D.O.B</b>		<b>Gender</b>	
<b>Contact details</b>	Home		Mobile		
<b>Email address</b>					
<b>Language spoken at home:</b>	English	<b>Interpreter required</b>		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
<b>Preferred option for communication</b>	<input checked="" type="checkbox"/> Email <input type="checkbox"/> Post <input type="checkbox"/> Phone		<b>Do you identify as Aboriginal and Torres Strait Islander?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>Residential Address:</b>					
<b>Postal Address (if different from above)</b>					

Is there a Guardianship and/or Administration order in place?

Yes  No

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below

<b>Name of Parent/Guardian 1</b>		<b>Primary Carer</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Lives with Participant</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		<b>Emergency Contact</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Relationship to participant</b>	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Other			
<b>Residential Address:</b>				
<b>Postal Address (if different from above)</b>				
<b>Contact details</b>	Home		Mobile	
<b>Email address</b>				

Name of Parent/Guardian 2	Primary Carer		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lives with Participant		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Emergency Contact		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Relationship to participant	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caregiver <input type="checkbox"/> Other			
Residential Address:				
Postal Address (if different from above)				
Contact details	Home		Mobile	
Email address				

### 1. Disability / Medical Conditions

Intellectual disability

### Other service providers currently using (include Supported Independent Living SIL Provider)

Name	
Address	
Phone number/email	
Frequency of use:	

Name	
Address	
Phone number/email	
Frequency of use:	

Name	
Address	
Phone number/email	
Frequency of use:	

**2. Requirements of personal space and access requirements in accommodation (wheelchair, bathroom, kitchen etc)**


**3. Preferences including what you are looking for in your accommodation**

Preferred name	
Religious Requirements	
Cultural Requirements	
Communication device	
Physical Assistance	
Other Considerations	

#### 4. Funding

NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIA managed participants)

NDIS Number:	
NDIS Date:	

Self-Managed  Plan Managed

Please provide details for invoices

Name	
Email	
Comments	

I understand that:

- These records are owned by this organisation.
- Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties
- I can ask to see records and receive a copy
- Records are archived for a set period according to policy and procedure
- I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Signature of Participant or Parent/Caregiver: \_ \_ \_ \_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to participant: \_\_ Support Coordinator \_\_\_\_\_