**RFS - My Care Provider (Version July.23)**

*What has changed? New plan, new dates, new circumstances, new allocation of funds?*

|  |  |
| --- | --- |
| **Today’s date (date referred):** |  |
| **Service to be delivered by:** |  |
| **Participant name:** |  |
| **NDIS number:** |  |
| **Date of birth:** |  |
| **Address:** |  |
| **Participant contact phone:** |  |
| **Or contact person (relation?) inc. contact details:** |  |
| **Participant or contact person email address:** |  |
| **Email addresses for report:** |  |
| **NEW Plan start date:** |  | **Plan end date:** |  |
| **CB Improved Daily Living billing details:** | [ ]  NDIS [ ]  Plan management [ ]  Self-managed |
| **Plan Manager or Self-Managed details for invoicing purposes:** | Name: Contact Number: Email Address for invoices:   |
| **Is the participant’s Core billing details the same as listed above?:** | Y/N - (Please provide details if different from above) |

|  |  |
| --- | --- |
| **What is the outcome that you are seeking (please clearly state what you are wanting from the referral):** | What do you want to get out of making this referral?CB Improved Daily Living Supports (15\_):Y/N - Functional Assessment Report (10hrs, $1939.90)Y/N - Occupational Therapy intervention ($193.99 p/h)Y/N - Allied Health Assistant intervention ($86.79 p/h) Y/N - suitable for one of our 6-8 week group programs?  ($1,550 - $3,100 depending on which)Core Assistance with Social, Economic and Community Participation Supports (04\_): Y/N - Support Worker Standard Intervention Weekday Daytime ($66.45 p/h)**How much are you allocating for the above supports (including travel time)?:**TOTAL AMOUNT OT: $ TOTAL AMOUNT AHA: $ TOTAL AMOUNT Support Worker: $TOTAL AMOUNT Group Programs: $  |

|  |  |
| --- | --- |
| **Other services, supports or relevant contacts worth noting:**  |  |

**NDIS Coordinator details (if applicable)**

|  |  |
| --- | --- |
| **Name:** |  |
| **Contact number:** |  |
| **Email address:** |  |

**Anything that has changed (living arrangements, carers, presentation, employment) that we should know about?**

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|   |

**NEW Plan Goals (please attach the current plan or an NDIS document)**

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| --- | --- |
| **Goal:** |  |
| **Goal:** |  |
| **Goal:** |  |
| **Goal:** |  |

Please **attach any relevant assessment reports** that have been completed to date, as these will offer valuable insights.

I/we look forward to working collaboratively with you and/or your participant.

Thank you for taking the time to complete this form in full.



**Mike Harris**

Director / Snr. Occupational Therapist

My Care Provider

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* Please attach the NDIS Plan or an NDIS doc -