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

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

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| --- | --- | --- | --- |
| **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) | | |

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| **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: $ |

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| **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 -