|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NEW CLIENT FORM  ndis participant | | | | | | | | A close up of a sign  AI-generated content may be incorrect. |
|  | | | | | | | | |
| full name: | | |  |  | Phone: | | |  |
|  | | |  |  |  | | |  |
| DOB: | | |  |  | NDIS Number: | | |  |
|  | | |  |  |  | | |  |
| Email: | | |  |  | NDIS Plan Start: | | |  |
|  | | |  |  |  | | |  |
| Address: | | |  |  | NDIS Plan Finish: | | |  |
|  | | |  |  |  | | |  |
| Support Coordinator: | | |  |  | Phone/email: | | |  |
|  | | |  |  |  | | |  |
|  | | |  |  |  | | |  |
| Emergency Contact: | | |  |  | Phone/email: | | |  |
|  | | | | | | | | |
| Payments | | | | | | | | |
| **Access Community, Social and Rec Activities – Standard**  **SUPPORT – Innovative Community Participation** | | | | | | | | |
|  | Invoices emailed to: | |  |  |  | ABN: | |  |
|  | | | | | | | | |
| Plan Manager: | | |  |  | Phone/Email: | | |  |
|  | | |  |  |  | | |  |
| Self-Managed: | | |  |  | Phone/Email: | | |  |
|  | | |  |  |  | | |  |
| **Condition of participant: [MUST BE COMPLETED AND DETAILS PROVIDED PRIOR TO CTD SERVICES]** | | | | | | | | |
|  | | | | | | | | |
|  | | Acquired brain injury  Autism  Cerebral Palsy  Hearing impairment  Intellectual Disability, Developmental delay, Global developmental delay, Down Syndrome  Multiple Sclerosis  Psychosocial disability:  Spinal cord injury  Stroke  Vision impaired  Other – please specify:- | | | | | | |
|  | | | | | | | | |
| **Risk Management.** This information must be disclosed to provide a safe environment for both participants and supporters. List all risks, behaviours, and/or medical conditions. Please specify:- | | | | | | | | |
| **Does the participant have a Behavioural Support Plan:**  **Yes**  **No**  *Unsociable behaviours that are not reported at the time of signing this form or are not included in the Behavioural Support Plan provided can result in Carers That Drive declining support immediately to resolve the issue for all parties.*  **Does the participant have an Epilepsy Management Plan:**  **Yes**  **No**  *If answered Yes, a copy of the plan must be provided prior to commencement of any booking.*  **Does the participant require assistance in and out of the vehicle:**  **Yes**  **No**  **Does the participant have a mobility aid:**  **Yes**  **No**  Walker  Stick  Collapsable wheelchair  Other:-  **Will there be any other person/s accompanying the participant:**  **Yes**  **No**  **Will a companion animal be accompanying the participant:**  **Yes**  **No**  *If answered Yes, a companion form to be signed; emailed separately.*  **Participant’s likes, dislikes, interests, hobbies etc. -** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Booking service details** | | | | | | | | |
| Community Access  Day Program  Medical appointment  School  Specialist appointment  Therapy session  Work  Other:- | | | | | | | | |
|  | | | | | | | | |
|  | | **Start Date:**  **Pick up from:**  **Pick up time:**  **Take to:**  **One way**  **Return**  **2-hrs (min)**  **3-hrs**  **4-hrs**  **5+hrs**  **Ad hoc**  **One off** | |  |  | | **Daily**  **Weekly**  **Fortnightly**  **Every 4-weeks**   **Monthly**  **Evenings**  **Mon**   **Tues**  **Weds**  **Thurs**  **Fri**  **Sat**  **Sun**  **Tolls/parking:**  **Yes**  **No**  **Check**  **Disability Parking Permit:**  **Yes**  **No**  **Support Worker Preference:**  **Male**  **Female**  **Both** | |
|  | | | | | | | | |
|  | | **How Did You Hear About Us:**  Internet search  Word of mouth  social media  Other – please specify - | | | | | | |

**SIGNATURE REQUIRED.**

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| **Waiver and Release Authority** |
| This is to release Carers That Drive and/or the Community Access Supporters from liability when driving and helping clients/participants on outings.  Client Full Name -  Phone -  Address -   1. agree to abide by any of Carers That Drive’s rules, and any direction or instruction given to me by or on behalf of Carers That Drive in connection with my participation in outings; and 2. hereby release, waive, discharge and hold harmless Carers that Drive, its employees, officers and Community Access Supporters from any liability for personal injury, loss or damage to personal property associated with my participation in outings facilitated by Carers That Drive, whether caused by negligence, wilful act or omission, breach of contract, breach of statutory duty, error or otherwise.   Where this form is signed by the Participant’s nominee or representative, by signing this form the nominee/representative agrees to the release provided above for the benefit of the Participant and as a necessary condition of the Participant’s participation in outings. The nominee/representative also agrees to release Carers That Drive from any and all liabilities arising from the Participant’s involvement or participation in Outings. |

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| **In Carers That Drive COMMUNITY ACCESS SUPPORTER’S CAR** |
| Complete this section if being taken out in a Community Access Supporters car.  I authorise the use of various Supporter cars to take me out. |

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| --- |
| **Consent Agreement** |
| By signing this form, you give consent to the following:   * Carers That Drive have a copy of my NDIS plan details. * Store my information on their secure database including my plan and any other relevant documents such as, but not limited to, Behavioural Support Plan or Epilepsy Management Plan. * Exchange information with my support network, including but not limited to case managers, medical practitioners, allied health professionals and support coordinators. * Can opt out of being contacted by NDIS Third Party auditors during the verification/certification process. * Agree that any unsociable behaviours that are not reported at the time of signing this form or are not included in the Behavioural Support Plan provided can result in Carers That Drive declining support immediately to resolve the issue for all parties. * Provide a minimum of 30 days’ notice if changing Plan Managers and/or Support Coordinators. Unpaid invoices as a result if not notified of these changes will be collected personally. * Our services encourage self-advocacy where possible; we **do not provide in-home care**. * Management and Assessment information provided prior to commencement of bookings. * Signing this form does not equate to bookings made until such a time as the quote has been approved by all parties. |

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| --- | --- | --- | --- | --- |
| Client  signature: |  |  | Full Name  Date |  |
|  |  |  |  |  |
| Representative  signature  If signing on behalf of Client |  |  | Full Name  Date |  |