Participant Support Plan

Participant information			
Participant Name		DOB	
Phone		Email	
Address		Living Arrangement *(e.g. alone, with family, in unmodified or modified home/unit, support accommodation)*	
Today's Date:		Scheduled Review Date (6-12 months unless otherwise agreed with the Participant):	
First Plan or Plan Review?		Worker Name:	
Is the Participant Aboriginal and Torres Strait Islander(ATSIC)?		Does the Participant need access to ATSIC services	
Disability/Diagnosis		Health conditions (Physical, Mental Health etc)	
GP Name (if applicable)		GP Contact Details (if applicable)	
Is there anyone the Participant would like involved in the support plan?		Does the Participant have a Representative such as a nominee or guardian?	

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Representative Name (if applicable)		Representative Contact Details (if applicable	
What is your preferred communication style or contact method? (Tick all that apply)	☐ Face to face	☐ Phone	☐ Email only
	☐ Follow up with phone call	☐ Zoom	☐ Lots of reminders
	☐ Do not communicate with me	☐ Easy English	☐ Social Media Service
Emergency Arrangements Has a Participant Emergency Plan been completed in collaboration with the participant?		☐ Yes ☐ No If answered No, specify why: *(e.g. not relevant due to online supports etc* Are there any specific support needs that we need to consider if there was an emergency or disaster?	

Communication			
Type	☐ Verbal ☐ Non-Verbal ☐ Communication aids required ☐ Other:	Are you of a culturally or linguistically diverse background?	☐ Yes ☐ No

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Languages Spoken	☐ English ☐ Other Details:	Is an Interpreter required?	☐ Yes ☐ No
Do you have any culture, diversity, values and beliefs of which we should be aware?	☐ Yes ☐ No	If Yes please provide details	
How Participant expresses emerging health concerns		Systems for escalation in urgent health situations	
What is your preferred communication style or contact method? (Tick all that apply)	☐ Face to face	☐ Phone	☐ Email only
	☐ Follow up with phone call	☐ Zoom	☐ Lots of reminders
	☐ Do not communicate with me	☐ Easy English	☐ Social Media Service

NDIS Funding Information			
NDIS plan number:		Funding Type	☐ Self Managed ☐ Plan Managed ☐ NDIA Managed
Plan start date:		Plan end date:	
Appropriate Funding Available	☐ Yes	Which Funds Available	☐ Core Supports

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	☐ No		☐ Capacity Building Supports ☐ Capital Supports
Plan Managers Details (if applicable)		Has a copy of the plan been provided?	☐ Yes ☐ No
Are any supports being provided by another provider	☐ Yes ☐ No	Other Providers Details (if applicable)	
Is the Participant happy for us to collaborate with and share information to assist in service provision?	☐ Yes ☐ No	List Service Providers to collaborate with (if applicable)	

How can we assist you	
Which services are you interested in?	
What are your preventative Health Needs? *Do you need our support to access dentist appointments, vaccinations or other allied health services?*	

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Functional Requirements	Requirement	Applicability	Details of aid/assistance required
	Housework	☐ Needs Assistance ☐ No Assistance Needed	
	Transport	☐ Needs Assistance ☐ No Assistance Needed	
	Shopping (has transport)	☐ Needs Assistance ☐ No Assistance Needed	
	Meal preparation	☐ Needs Assistance ☐ No Assistance Needed	
	Eating	☐ Needs Assistance ☐ No Assistance Needed	
	Taking oral medication	☐ Needs Assistance ☐ No Assistance Needed	
	Handling money	☐ Needs Assistance ☐ No Assistance Needed	
	Telephone	☐ Needs Assistance ☐ No Assistance Needed	
	Mobility	☐ Needs Assistance	

		☐ No Assistance Needed	
	Transfers Bed/chair	☐ Needs Assistance ☐ No Assistance Needed	
	Bathing/Showering	☐ Needs Assistance ☐ No Assistance Needed	
	Oral care	☐ Needs Assistance ☐ No Assistance Needed	
	Dressing	☐ Needs Assistance ☐ No Assistance Needed	
	Grooming (makeup, hair, nails, shaving)	☐ Needs Assistance ☐ No Assistance Needed	
	Toileting	☐ Needs Assistance ☐ No Assistance Needed	
Health requirements	**Requirement**	**Applicability**	**Details of aid/assistance required**
	Medical Checkups	☐ Needs Assistance ☐ No Assistance Needed	
	Dental Appointments	☐ Needs Assistance	

		☐ No Assistance Needed	
	Allied Health Appointments	☐ Needs Assistance ☐ No Assistance Needed	
	Vaccination Appointments	☐ Needs Assistance ☐ No Assistance Needed	
	Continence	☐ Needs Assistance ☐ No Assistance Needed	
	Skin Integrity	☐ Needs Assistance ☐No Assistance Needed	
	Swallowing	☐ Needs Assistance ☐ No Assistance Needed	
	Muscular pain	☐ Needs Assistance ☐ No Assistance Needed	
	Nerve pain	☐ Needs Assistance ☐ No Assistance Needed	
	Falls	☐ Needs Assistance ☐ No Assistance Needed	

	Muscular issues (other than pain)	☐ Needs Assistance ☐ No Assistance Needed	
	Other health concerns	☐ Needs Assistance ☐ No Assistance Needed	
Behavioural Requirements	**Issue**	**Applicability**	**Details of aid/assistance required**
	Communication	☐ Needs Assistance ☐ No Assistance Needed	
	Memory	☐ Needs Assistance ☐ No Assistance Needed	
	Concentration	☐ Needs Assistance ☐ No Assistance Needed	
	Planning	☐ Needs Assistance ☐ No Assistance Needed	
	Decision Making	☐ Needs Assistance ☐ No Assistance Needed	
	Mood	☐ Needs Assistance ☐ No Assistance Needed	

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Social Requirements	Activities	Applicability	Activity details *(type, time spent, the assistance required)*
	Family	☐ Needs Assistance ☐ No Assistance Needed	
	Hobbies & Interests	☐ Needs Assistance ☐ No Assistance Needed	
	Religion & spirituality	☐ Needs Assistance ☐ No Assistance Needed	
	Outings	☐ Needs Assistance ☐ No Assistance Needed	
	Computer	☐ Needs Assistance ☐ No Assistance Needed	
	Employment	☐ Needs Assistance ☐ No Assistance Needed	
	Sports	☐ Needs Assistance ☐ No Assistance Needed	
	Music	☐ Needs Assistance ☐ No Assistance Needed	

	Movies/TV	☐ Needs Assistance ☐ No Assistance Needed	
	Food and alcohol	☐ Needs Assistance ☐ No Assistance Needed	
	Sex and intimacy	☐ Needs Assistance ☐ No Assistance Needed	
	Other	☐ Needs Assistance ☐ No Assistance Needed	
Mealtime Requirements	**Requirement**	**Applicability**	**Details *(if applicable)***
	Allergies	☐ Yes ☐ No	
	Intolerances	☐ Yes ☐ No	
	Vegetarian	☐ Yes ☐ No	
	Vegan	☐ Yes ☐ No	
	Other dietary requirements	☐ Yes	

		☐ No	
	Meal Plan Prepared	☐ Yes ☐ No	
	Nutrition or Swallowing Issues	☐ Yes ☐ No	
	Seating/Positioning requirements while eating or drinking	☐ Yes ☐ No	
	Any Food Preparation Requirements?	☐ Yes ☐ No	

Your Goals	**How do you see us supporting you with this?**
Goal 1:	

Goal 2:	
Goal 3:	
Goal 4:	
Strengths	
What are your strengths? Tell us how we can help utilise them while we support you *Strengths can be things like - I'm patient, I'm empathetic, I am great at time management, I am very loving, I am a hard worker etc.*	

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Worker Matching
We value getting the right Worker match for your needs considering factors like personality, language, culture, and skills. We want you to be part of this matching process and can help you find an advocate if you wish. Can you tell us about the characteristics you'd like in your Support Worker?
What else would you like us to know?

Administration Requirements	
Has this document been completed with the participant?	☐ Yes ☐ No
Has a Risk Assessment Form been completed with the Participant?	☐ Yes ☐ No

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Would you agree to let us arrange for a qualified and/or experienced worker from Brighter Road to temporarily provide support to you, should there be an emergency or if your regular worker is unavailable?	☐ Yes ☐ No
If an emergency arises, would you permit us to collaborate with an external agency or contractor for short-term assistance, or to fill the position if needed?	☐ Yes ☐ No
If an unplanned absence turns into a permanent one, are you comfortable with us finding a new worker to permanently take on the role?	☐ Yes ☐ No
Would you like us to share details about your support plan with your family, caregivers, other service providers, and pertinent government agencies?	☐ Yes ☐ No
Is this support plan stored in a location where the Participant can easily access it?	☐ Yes ☐ No
Is the support plan kept in a place that's easily accessible to Brighter Road?	☐ Yes ☐ No
Has an Individualised Plan been developed for this Participant in case of emergencies?	☐ Yes ☐ No

Participant Support Plan

Please sign below to indicate your consent to the prepared Participant Support Plan:

Brighter Road's Representative Name:	
Signature:	Date:

Participant's Worker's Name:	
Signature:	Date:

Participant Name:	
Signature:	Date:

Participant's Representative Name (if applicable):	
Signature:	Date:

Interpreter Name (if applicable):	
Signature:	Date: