



Participant Support Plan

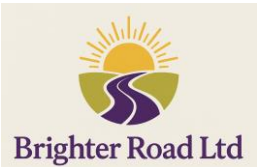
Participant information			
Participant Name		DOB	
Phone		Email	
Address		Living Arrangement (<i>e.g. alone, with family, in unmodified or modified home/unit, support accommodation</i>)	
Today's Date:		Scheduled Review Date (6-12 months unless otherwise agreed with the Participant):	
First Plan or Plan 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)	<input type="checkbox"/> Face to face	<input type="checkbox"/> Phone	<input type="checkbox"/> Email only
	<input type="checkbox"/> Follow up with phone call	<input type="checkbox"/> Zoom	<input type="checkbox"/> Lots of reminders
	<input type="checkbox"/> Do not communicate with me	<input type="checkbox"/> Easy English	<input type="checkbox"/> Social Media Service
Emergency Arrangements Has a Participant Emergency Plan been completed in collaboration with the participant?		<input type="checkbox"/> Yes <input type="checkbox"/> No If answered No, specify why: <i>(e.g. not relevant due to online supports etc)</i> Are there any specific support needs that we need to consider if there was an emergency or disaster?	

Communication			
Type	<input type="checkbox"/> Verbal <input type="checkbox"/> Non-Verbal <input type="checkbox"/> Communication aids required <input type="checkbox"/> Other:	Are you of a culturally or linguistically diverse background?	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Languages Spoken	<input type="checkbox"/> English <input type="checkbox"/> Other Details:	Is an Interpreter required?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any culture, diversity, values and beliefs of which we should be aware?	<input type="checkbox"/> Yes <input type="checkbox"/> 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)	<input type="checkbox"/> Face to face	<input type="checkbox"/> Phone	<input type="checkbox"/> Email only
	<input type="checkbox"/> Follow up with phone call	<input type="checkbox"/> Zoom	<input type="checkbox"/> Lots of reminders
	<input type="checkbox"/> Do not communicate with me	<input type="checkbox"/> Easy English	<input type="checkbox"/> Social Media Service

NDIS Funding Information			
NDIS plan number:		Funding Type	<input type="checkbox"/> Self Managed <input type="checkbox"/> Plan Managed <input type="checkbox"/> NDIA Managed
Plan start date:		Plan end date:	
Appropriate Funding Available	<input type="checkbox"/> Yes	Which Funds Available	<input type="checkbox"/> Core Supports



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	<input type="checkbox"/> No		<input type="checkbox"/> Capacity Building Supports <input type="checkbox"/> Capital Supports
Plan Managers Details (if applicable)		Has a copy of the plan been provided?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are any supports being provided by another provider	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Providers Details (if applicable)	
Is the Participant happy for us to collaborate with and share information to assist in service provision?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? <i>Do you need our support to access dentist appointments, vaccinations or other allied health services?</i>	

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Functional Requirements	Requirement	Applicability	Details of aid/assistance required
	Housework	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Transport	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Shopping (has transport)	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Meal preparation	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Eating	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Taking oral medication	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Handling money	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Telephone	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Mobility	<input type="checkbox"/> Needs Assistance	

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		<input type="checkbox"/> No Assistance Needed	
	Transfers Bed/chair	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Bathing/Showering	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Oral care	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Dressing	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Grooming (makeup, hair, nails, shaving)	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Toileting	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
Health requirements	Requirement	Applicability	Details of aid/assistance required
	Medical Checkups	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Dental Appointments	<input type="checkbox"/> Needs Assistance	

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		<input type="checkbox"/> No Assistance Needed	
	Allied Health Appointments	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Vaccination Appointments	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Continence	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Skin Integrity	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Swallowing	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Muscular pain	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Nerve pain	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Falls	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	

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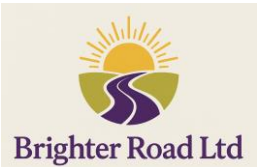
	Muscular issues (other than pain)	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Other health concerns	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
Behavioural Requirements	Issue	Applicability	Details of aid/assistance required
	Communication	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Memory	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Concentration	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Planning	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Decision Making	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Mood	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	

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Social Requirements	Activities	Applicability	Activity details (<i>type, time spent, the assistance required</i>)
	Family	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Hobbies & Interests	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Religion & spirituality	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Outings	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Computer	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Employment	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Sports	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Music	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	

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	Movies/TV	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Food and alcohol	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Sex and intimacy	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
	Other	<input type="checkbox"/> Needs Assistance <input type="checkbox"/> No Assistance Needed	
Mealtime Requirements	Requirement	Applicability	Details (if applicable)
	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Intolerances	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vegetarian	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Vegan	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Other dietary requirements	<input type="checkbox"/> Yes	



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		<input type="checkbox"/> No	
	Meal Plan Prepared	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Nutrition or Swallowing Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Seating/Positioning requirements while eating or drinking	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Any Food Preparation Requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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



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Goal 2:	
Goal 3:	
Goal 4:	
Strengths	
<i>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.</i>	



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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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like us to share details about your support plan with your family, caregivers, other service providers, and pertinent government agencies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this support plan stored in a location where the Participant can easily access it?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the support plan kept in a place that's easily accessible to Brighter Road?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has an Individualised Plan been developed for this Participant in case of emergencies?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: