Limitless Care Australia
SERVICE REQUEST FORM

This form is completed for Referrals to Limitless Care Australia and is for use as online or print out version.							
REFERRED BY:							
Name		**Title**					
Agency		**Contact No:**					
PARTICIPANT DETAILS							
Participant Name		**Contact No:**					
Participant Age		**Date of Birth**					
Carer		**Contact No:**					
Address:							
Email:							
NDIA N0:		**Start date:**		**End date:**			
Does the person speak English?	**Yes**	☐	**No**	☐			
If No, what language is spoken?							
Is an Interpreter Service required for the Interview?					**Yes**	☐	**No** ☐
Name of Interpreter Service		**Contact No:**					
Are the Participant from Aboriginal or Torres Strait Islander descent?					**Yes**	☐	**No** ☐
If Yes, do they have a Case Worker?					**Yes**	☐	**No** ☐
Do they want them involved in their Respite Care Planning?					**Yes**	☐	**No** ☐
Name of Case Worker		**Contact No:**					
Email Address							
Does the Participant have a Guardian?					**Yes**	☐	**No** ☐
If Yes, Name		**Contact No:**					
Email Address							
Does the Participant have an Advocate?					**Yes**	☐	**No** ☐
If Yes, Name		**Contact No:**					
Email Address							

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Reason for Referral **Respite Type and frequency of service requested** **Urgency**	**Daily Activities Social & Community Access Skill Development Overnight**
Does the NDIS plan include transport funding for social & community participation?	**Yes/No**
	If Yes, Is there funding available to charge for transport at ? **Yes/No** **If No, and the participant travels in the Support Worker's vehicle, the time spent travelling will be calculated and charged to the plan against the related support line item – in accordance with NDIS guidelines. E.g. 2 hr shift including 30 mins of travel will be charged as 2.5hrs – travel will be charged in 10-minute increments**
How is this funding managed?	**Agency/Plan Managed/Self-Managed**
Does the participant have any additional support needs? **i.e. Behaviour /OT/ Epilepsy /Asthma**	**Yes/No**
	If Yes – a copy of the specific support plan will be required **Please ensure that this is available for the Intake meeting.**

QUALITY MANAGER FOLLOW-UP			
Date of First Contact:		**Interview Date and Time**	
Interview Address if different to above:			

NOTES:			
Signed		**Date:**	