Support Plan

Instructions:
1. Please read and explain this document to participants who require additional support. 2. Consult and seek assistance from participants

Date of Plan

Next Review Date

☐ Review Date Scheduled in Tasks

1 Personal Details

Participant Name

Date of Birth

Age

NDIS Number

2 Communication Needs *(How we talk to you)*

Cultural Background

Language Spoken

Communication Preferred by Participant

☐ Easy Read ☐ Verbal Explanation ☐ Interpreter

Needs an Interpreter

☐ Yes ☐ No

Language

Staff Access to Support Plan Method (Informed of participant's need and ability to access for participants as required)

Decision Making

☐ Self ☐ Parent ☐ Guardian ☐ Nominee ☐ Other

What assistance (if any, is needed?)

3 Development of the Plan *(include Participant in list if participating) (Your family/advocate who helps)*

Person 1 Name

Role

Manner of Participation (e.g. attend meeting)

Person 2 Name ☐ Role ☐ Manner of Participation (e.g. attend meeting) ☐

Person 3 Name ☐ Role ☐ Manner of Participation (e.g. attend meeting) ☐

If the participant did not participa » • in this plan, document reason/s?

4 Assessments Conducted *(Information that tells us about you)*

Not applicable ☐

Assessments that Inform this Support Plan	Date	Conducted By	Date of Review

5 Challenging Behaviours

Are there any known challenging behaviours?

☐ Yes ☐ No

Comments

6 Behaviour Support Plan – Implementation *(Your behaviour support)*

Not applicable ☐

Behaviour Support Plan on NDIS Portal Required to meet authorisation requirements: ☐ Yes ☐ No

Completed Behaviour Support Plan is in place and attached to this Support Plan: ☐ Yes ☐ No

List specific restrictive practices required to support the participant: 1.

2.

3.

7 Client Needs Assessment and/or Concerns

Needs or concerns

1.

2.

3.

Emotional Needs - List any emotional needs that the participant may require.

Social Needs - List any social needs that the participant has. (e.g. does the participant enjoy group activities, are they happy in crowds, etc.)

Communication/Social Skills - List any communication/social needs that the participant may have. (e.g. participant has trouble being understood etc.)

Vocation Pursuits - List any vocational pursuits the participant is interested in.

Physical Needs - List any physical needs/supports that the participant may require.

Recreational/Leisure - List any recreational/leisure interests the participant enjoys. (e.g. picnics, bowling, rock climbing etc.)

Other Needs - List any other needs, interests or requirements not listed above.)

Support Needs - List preferred support days/hours, details of support worker preferences etc.)

Therapy Needs

8 Participant Goals

Participant Goals

Actions and Tasks (How will participant achieve goal)

What supports are required to assist participant to achieve goal:

Who will support the participant to achieve their goals:

Timeframes to achieve goal:

Outcomes

Participant Goals

Actions and Tasks (How will participant achieve goal)

What supports are required to assist participant to achieve goal:

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Participant Goals

Actions and Tasks (How will participant achieve goal)

What supports are required to assist participant to achieve goal:

Who will support the participant to achieve their goals:

Timeframes to achieve goal:

Outcomes

9 Health and Medical *(Your health and medical support)*

Not applicable ☐

Plans in Place

☐ Behaviour Support Plan ☐ Asthma ☐ Epilepsy ☐ Anaphylaxis ☐ High Intensity Care Plan ☐ Mealtime Management Plan

Issues or Concerns

Strengths

Vaccinations are up to date:

☐ Yes ☐ No

Comments

10 Medication Support *(Support with your medication)*

Does the participant require the provider to provide supports around medication? Please choose the appropriate response.

☐ I have **no** medications ☐ I can medicate **myself 100%** ☐ I require **prompting only**: I can physically choose the correct medication, time and dose

☐ I require **assisting**: I need you to get it for me ☐ I require you to **administer** it for me

Note – if assistance or administering of medication is required, complete medication consent/authorisation forms.

Provide details of any regular medication *(regardless of how it is administered)*

Medication Name	Type	Dosage	Reason for Medication

11 Vaccination Support *(Support you during your vaccinations)*

No action required ☐

Does the participant require the provider to provide supports around vaccinations? ☐ Yes ☐ No

Comments

Preparing the Participant

Transportation

Vaccination Provision Strategy

12 Comprehensive Health Assessment

Does the participant require the provider to provide supports around annual checkups? ☐ Yes ☐ No

Comments

This is undertaken between GP and Participant. Record Dr Details.

Doctor	Address	Phone Number

13 Allied Health Services *(Your specialist supports, eg. physio, OT, speech etc)*

Type of Service	Utilised	Needed	Practitioner	Phone
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

14 Oral Health

Does the participant require the provider to provide supports around annual checkups? ☐ Yes ☐ No

Comments

Daily Care (times, method)

Check-Up Booked? ☐ Yes ☐ No

Check-Up Date

Dentist Name

Address

Phone Number

15 Delivery of Support Risk Assessment (informed by Participant Individual Risk Assessment & Management Plan) *(Risk or issues to support you)*

** Please refer to Participant Risk Assessment located in participant file.

No Action Planned ☐

16 Personal Emergency Preparation Plan (note: must be kept up to date)

**Please refer to Participant Emergency and Disaster Plan located in participant file

17 Money and Property

Does the participant require supports from the provider around the management of money and/or property? ☐ Yes ☐ No

If yes, complete *Participant Financial Consent Form.*

Comments

18 Medical Emergency Response Plan

No Action Planned ☐

Please complete protocols for participant. Only complete for urgent health situations eg. Anaphylaxis, choking, serious injury, psychiatric etc.

Potential Medical Emergency	Signs and Symptoms	Immediate Agreed Response & Escalation - point where escalation occurs, explain response e.g. contacting ambulance	Contact Person

19 Continuity of Supports Arrangements *(Person who will help you when your carer is away)*

Provide details e.g., replacement staff/other providers. Inform the participant and gain their approval for replacement. Check here if pre-approved by the participant.

Staff Member / Provider	Contact Details	Participant Approval
		☐ Yes ☐ No
		☐ Yes ☐ No

20 Support Plan Provided to: *(Giving you a plan)*

☐ Participant ☐ Guardian ☐ Advocate ☐ Nominee ☐ Other

Participant declined copy of Support Plan ☐ Yes ☐ No

Participant Representative Name

	☐ Yes ☐ No
	☐ Yes ☐ No

21 Participant Acknowledgement *(Sign that you have been told about your plan)*

- [ ] This support plan has been explained to me in my preferred communication style.
- [ ] I understand and agree to this Support Plan.
- [ ] I agree to my Support Plan being provided to the person/s listed above.

Participant/Advocate	Signature	Date

Prepared By (worker)	Signature	Date

Approved By	Signature	Date

22 Key to Support Plan Notes

1. Date plan was completed, and participant signed plan.
2. Date of next review.
3. Write participant's name, date of birth and age.
4. Brief description of why the participant did not participate, such as: declined invitations to give views, complete self-questionnaire, convey views to third party or just accepted recommendations.
5. Ensure that any Individual Risk Profile assessments and all other assessments that informed the Support Plan are included here. Only list assessments that are relevant to this plan. Note, the Individual Risk Profile assessment is compulsory, as such has been included permanently and should be attached and filed.
6. The date the assessment was completed to show how current it is.
7. Write the person's title.
8. If a review is expected, state the date. If there are no plans for review, write 'n/a'. If it is considered that a review should take place, this should be incorporated into the relevant section of the support plan, but not here. The review should be listed in this section on completion.
9. Outline the main issues as raised by the participant and participant representative. State any contradictory or dissenting views and what he or she disagreed with. Issues can be addressed in the body of the plan and documented in notes as appropriate.
10. Tick box if no Participant Goals, actions or tasks are noted for this domain on this plan. Issues or concerns and strengths can still be noted, as well as measures already in place, even if no current action is planned.
11. Issue or concern related for the participant named on the plan, e.g. participant has a significant hoarding and/or cleaning issue or major safety risks have been identified within the home.
12. Strength related for the participant named on the plan, e.g. participant is in good health (health and medical) or participant has a good relationship with daughter (family relationships).
13. There is no minimum number of Participant Goals.
14. Clearly stated actions and tasks required to meet the objective.
15. Detail responsibilities for actions or tasks in the achievement of goals including responsibilities of the provider (i.e. staff, contractors, etc) and "other persons", i.e. live in carer, family, friends, volunteers
16. State and timeframe (how long and maybe period if only for a fixed period), this area will help guide the budget establishment
17. Include focus on overall identity and positive self-image building. For a sample of support plan strategies to support cultural maintenance of participants from culturally and linguistically diverse backgrounds see the *[....]*.
18. This section allows for the support worker to check that the participant and appropriate representatives are provided with a Support Plan. Discuss this with the participant and only provide the Support Plan to appropriate representatives where the participant has agreed to its release. Always provide the Support Plan to the participant.