Once completed, please send an electronic copy of this form to [info@Applecarecommunityservices.com.au](mailto:info@Applecarecommunityservices.com.au) or by mail to our office at 56 Portrush Road, Payneham, 5070 SA.

For any additional information or assistance with completing this form, contact the office at (08) 7081 5295 M 0421 425 015

|  |  |  |  |
| --- | --- | --- | --- |
| Personal details of the person being referred | | | |
| Enquiry/Referral Date: |  | | |
| Full Name: |  | | Date of Birth: |
| Gender: | Male | Female | Other |
| Address: |  | | |
| Postal Address:  (if different from above) |  | | |
| Contact Details: | Home Phone | Mobile | Email |
| Identifies as: | Aboriginal | Torres Strait Islander | Neither |
| Preferred Language/ dialect: |  | Interpreter required? | Yes  No |
| Copy of NDIS Plan provided: | | Yes  No | |
| The additional information you wish to share: | |  | |
| I give permission for this referral and understand that I will be contacted by Apple Care Community Servicesstaff | | | |
| Participant Name: |  | | (or primary carer/next of kin/guardian) |
| Signature: |  | | Date: |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Carer/Next of Kin/Guardian Details (if required) | | | |
| Full Name: |  | | |
| Relationship to Participant: |  | | |
| Postal Address: |  | | |
| Contact Details: | Home Phone | Mobile | Email |

|  |  |  |  |
| --- | --- | --- | --- |
| Disability (tick one or more if known) | | | |
| Autism | Neurological | Intellectual Disability | Physical |
| Sensory (e.g., vision, hearing) | Attributable to a psychiatric condition | Cognitive/Acquires Brain Injury | Development Delays |
| Other (please list) |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Services I would like to enquire about | | | |
| Supported Independent Living (SIL) | Short Term Accommodation (STA) | Medium Term Accommodation (STA) | Respite |
| Behaviour Support | Community Participation | Capacity Building | Other |
| If other, please list |  | | |

|  |  |  |
| --- | --- | --- |
| Referral details (if applicable) | | |
| Full Name: |  | |
| Organisation: |  | |
| Position Title: |  | |
| Address: |  | |
| Phone: |  | |
| Email: |  | |
| Signature: |  | Date: |

**What happens after we receive your information?**

Once we receive your enquiry/referral, a staff member will contact you to develop a Service Agreement. The Service Agreement will need to be approved and signed before any services or supports commence. We will work with the NDIS participant and/or their representative to ensure the Service Agreement is based around the participant’s needs and goals.