PHENDIT ICAN SUPPORT PROGRAM – CLIENT INTAKE FORM

"Partner in Hope – Every Need Deserves Impactful Touch"

SECTION 1: APPLICANT DETAILS

Full Name: _____

Preferred Name: _____

Date of Birth: ____ / ____ / _____

Gender (Optional): ☐ Male ☐ Female ☐ Non-binary ☐ Prefer not to say

Phone Number: _____

Email Address: _____

Residential Address: _____

Emergency Contact Name: _____

Emergency Contact Relationship: _____

Emergency Contact Phone: _____

SECTION 2: NDIS INFORMATION

Are you an NDIS Participant?
☐ Yes
☐ No (Applying / Awaiting Access)

NDIS Number (if applicable): _____

Plan Type:
☐ NDIA Managed
☐ Plan Managed
☐ Self Managed

Plan Manager Name (if applicable): _____

Plan Manager Email: _____

Support Coordinator Name (if applicable): _____

Support Coordinator Organisation: _____

Support Coordinator Contact: _____

SECTION 3: ICAN PROGRAM ELIGIBILITY QUESTIONS

(Used to assess support priority and eligibility)

1. Are you currently experiencing funding limitations that prevent you from accessing required supports?

☐ Yes
☐ No

If yes, please explain:

_____

_____

2. What challenges are you currently facing?

(Tick all that apply)

☐ Insufficient NDIS funding
☐ Waiting for plan review
☐ Waiting for access decision
☐ Complex support needs
☐ Risk of hospitalisation or placement breakdown
☐ Housing instability
☐ Mental health challenges
☐ Limited informal supports
☐ Other: _____

_____

3. What immediate support are you requesting through ICAN?

☐ Short Term Accommodation (STA / Respite)
☐ In-home support
☐ Community access
☐ Transport assistance
☐ Meal preparation
☐ Personal care
☐ Capacity building
☐ Emergency support
☐ Other: _____

_____

SECTION 4: SUPPORT REQUEST DETAILS

Preferred Support Location (if applicable):

Requested Start Date: ____ / ____ / _____

Requested End Date (if applicable): ____ / ____ / _____

Preferred Support Hours:

Support Ratio Required:
☐ 1:1
☐ 1:2
☐ Other: _____

SECTION 5: HEALTH & SAFETY INFORMATION

Do you have any diagnosed conditions we should be aware of?
☐ Yes ☐ No

If yes, please list:

Do you require medication support?
☐ Yes ☐ No

Any known risks or behavioural support needs?
☐ Yes ☐ No

If yes, explain:

Mobility Support Required?
☐ Wheelchair
☐ Walking aid
☐ Transfer assistance
☐ None

SECTION 6: CULTURAL, LANGUAGE & FAITH CONSIDERATIONS (Optional)

Preferred Language: _____

Interpreter Required? ☐ Yes ☐ No

Cultural considerations we should respect:

Faith-based support preference (optional):
☐ Christian support values preferred
☐ Neutral support preferred
☐ No preference

SECTION 7: CONSENT & DECLARATION

I confirm that the information provided in this form is accurate and truthful to the best of my knowledge.

I consent to Phendit Group collecting and using this information solely for service assessment, ICAN Program eligibility review, and support delivery purposes in accordance with privacy legislation.

Applicant Name: _____

Signature: _____

Date: ____ / ____ / _____

SECTION 8: OFFICE USE ONLY (PHENDIT ICAN TEAM)

ICAN Reference Number: _____

Eligibility Outcome:
☐ Approved
☐ Pending Review
☐ Declined

Reason (if declined):

Approved Support Type: _____

Assigned Coordinator: _____

Approval Officer: _____

Approval Date: ____ / ____ / _____