REFERRAL FORM PLAN MANAGEMENT

Participant Details: Date: ____ /____ /_____

Full Name: _____

Address: _____

Date of birth: _____ Phone number: _____

NDIS number: _____ Email address: _____

Plan start / end date: _____

Date of agreed service commencement: _____

Preferred contact details of participant:	
Primary Contact	**Is this person the plan nominee for this participant?** YES ☐ NO ☐
Name	
Relationship to participant (If applicable)	
Address	
Contact phone number	
Email address	
Special considerations	YES ☐ NO ☐

Participant would like to access to the Pathways to Care Participant Portal for their Plan	YES ☐ NO ☐
Participant would like to authorise their invoices before Pathways to Care process them	YES ☐ NO ☐
Participant would like someone else (up to 3 people) to receive their monthly statement	YES ☐ NO ☐

Do you have a copy of your Plan? YES ☐ NO ☐	**If Yes,** please attach and send with this referral form to: intake@pathwaystocare.com.au **If No,** please complete Financial Breakdown form on the next page and send to: intake@pathwaystocare.com.au.

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Financial Breakdown form		
Financial Intermediary Services (PMP)	☐ Financial & service intermediary activities ($ _____ – per hour)	☐ Set Up Costs ($ _____ – Once)
	☐ Financial intermediary monthly processing ($ _____ – per month)	Total funded in plan: $ _____
Budget items/supports for Plan Management: Complete if Known		
NDIS Plan Breakdown		
CORE SUPPORTS	Assistance with daily living	$
	Travel & Transport (mobility allowance)	$
	Consumables	$
	Assistance with social & community participant	$
CAPITAL SUPPORTS	Assistive Technology	$
	Home Modifications	$
CAPACITY BUILDING SUPPORTS	Improved Life Choices	$
	Improved Daily Living	$
	Improved Health & Well Being	$
	Improved Social & Community Participation	$
Support Coordinator / LAC Contact Details: (If Applicable)		
Contact person		
Contact organisation		
Contact phone number		
Contact email		
Contact address		
Other Information:		
How did you hear about Pathway's to Care Plan Management Provider Service?	☐ Flyer ☐ Pathways to Care Website ☐ Referred by a service provider ☐ Existing PTC participant	☐ NDIA or LAC recommended ☐ Social Media ☐ Word of mouth ☐ Other:

Request completed by:	_____	Date: ____ /____ /_____

Please return completed copy to: intake@pathwaystocare.com.au or 196 High St Bendigo Vic 3550