Hope Health & Care Services ABN 52 655 753 352
Client Support Plan

Getting to know you
Hope Health & Care Services appreciates that everyone is unique, please help us to get to know you by answering the following:

General Info					
Today's Date:					
Scheduled Review Date (every 6 months to a year unless otherwise agreed with the Client):					
Is this the Client's first Support Plan or a review of a previous Support Plan?					
Hope Health & Care Services Representative attending Support Planning meeting:					
Other persons involved in Support Planning:					
Client Name:			**Client DOB:**		
Address:					
My preferred contact method:			**Name of Enquirer:**		
My preferred emails:			**Enquirers Contact #:**		
How is Enquirer related:					
☐ **ATSI Information**	☐ **Aboriginal but not Torres Strait Islander origin**	☐ **Torres Strait Islander but not Aboriginal origin**	☐ **Both Aboriginal and Torres Strait Islander origin**	☐ **Neither Aboriginal or Torres Strait Islander origin**	☐ **Prefer not to answer**
Which services are you interested in?	☐ Assistance with Daily Life				

	☐ Transport ☐ Consumables ☐ Assistance with Social, Economic and Community Participation ☐ Assistive Technology ☐ Home Modifications and Specialised Disability Accommodation (SDA) ☐ Support Coordination ☐ Improved Living Arrangements ☐ Increased Social and Community Participation ☐ Finding and Keeping a Job ☐ Improved Relationships ☐ Improved Health and Wellbeing ☐ Improved Learning ☐ Improved Life Choices ☐ Improved Daily Living Skills

Living arrangements: (who do you live with?)	
Living environment: (e.g. unmodified or modified home/unit for my needs, support accommodation)	
Representative of Client's Name: (if applicable)	
Address:	Home phone: Mobile: Work:

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	Email:
Diagnosis:	Date of Diagnosis:
Medical History:	
GP Name:	
Address:	Work ph: Email:

Communication	
Type	☐ Verbal ☐ Non-Verbal ☐ Communication aids required ☐ Other: _____
Are you of a culturally or linguistically diverse background?	☐ Yes ☐ No Details:
Do you have any culture, diversity, values and beliefs	☐ Yes

of which we should be aware?	☐ No Details:
Languages Spoken	☐ English ☐ Other: _____
Is an Interpreter required?	☐ No ☐ Yes, because Client is hearing impaired ☐ Yes, for language reasons ☐ Yes, to ensure the support plan is provided to the Client in the mode of communication and terms they are most likely to understand. If yes, please provide details of the scheduled appointment with the interpreter:
I express emerging health concerns by:	Details:

Systems for escalation in urgent health situations.	Details:

A bit about you and your goals and support needs		
To help us understand you better, please fill the below:		
	My strengths are (what I am good at)...	
	I like...	

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	I don't like... (please include any sensory considerations)	
	You will know when I am happy by...	
	You will know when I am unhappy by...	
	I prefer to communicate by...	
	What are your goals for the next 12 months?	
	How have these goals changed since your previous Support Plan (if applicable)	
	How do your existing support from us or other providers help achieve desired outcomes? Is there any opportunity to use less intrusive options, in accordance	

	with contemporary evidence-informed practices that meet participant needs and help achieve desired outcomes.	

NDIS Funding Info			
NDIS plan no:			
Plan start date:		**Plan end date:**	
How is funding managed:	☐ **Self-managed**	☐ **Financial plan managed**	☐ **Agency**
Confirm appropriate funding:	☐ **Yes**	☐ **No**	
Which of the following funds are available for us in your plan?			
☐ **Core Supports**	☐ **Capacity Building Supports**	☐ **Capital Supports**	
Financial plan management information			
Are you happy to provide a copy of the plan?	☐ **Yes**	☐ **No**	

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Note: Providing your plan is not essential but is very helpful			
Are you receiving any support or services from other providers? If so, please list			
Are you happy for us to develop and maintain links, collaborate with and share information with these to help meet your needs?	☐ Yes (if so, in relation to some or all providers. List below)	☐ No (if so, in relation to some or all providers. List below)	

About your weekly schedule							
Time	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
6.00-7.00 am							
7.00-8.00 am							
8.00-9.00 am							
9.00-10.00 am							
10.00-11.00 am							

11.00-12.00							
12.00 – 1.00 pm							
1.00-2.00 pm							
2.00-3.00pm							
3.00-4.00 pm							
4.00-5.00 pm							
5.00-6.00 pm							
6.00-7.00 pm							
7.00-8.00 pm							
8.00-9.00 pm							
9.00-10.00 pm							
10.00 pm +							

Mealtime Management		
I have the following allergies/intolerances and my favourite food is...		
No dietary requirements	☐ **Yes**	☐ **No**
Meal Plan	☐ **Yes**	☐ **No**

Vegetarian	☐ Yes	☐ No
Vegan	☐ Yes	☐ No
I am allergic to (please list)		
I am unable to eat (sensory/intolerances)		
My favourite food is...		
I have issues with nutrition and swallowing	☐ Yes Details:	☐ No

I have specific seating and positioning requirements while eating or drinking	☐ **Yes** **Details:**	☐ **No**
My food or drinks needs to be specially prepared	☐ **Yes** **Details (please list preparation techniques or feeding equipment):**	☐ **No**

Hope Health & Care Services can assist me during mealtimes by...	
☐	I can identify what foods are safe for me to eat (if required due to allergy or dietary requirements).
☐	If I have a food allergy, I have provided Hope Health & Care Services with a management plan.

☐	If required I will bring any medications to assist me with my allergy and have completed the relevant medical forms
☐	I prefer to provide my own food and will do so

Mental Health			
I have/experience...			
☐	Depression	☐	Anxiety
☐	Psychosis	☐	Schizophrenia
☐	Bipolar	☐	Other
I would like Hope Health & Care Services to help me manage this by...			
My triggers may include...			
I am supported/linked with the following organisations who assist me… (Please supply relevant management plans.)			

☐	I have received medical support to assist me and Hope Health & Care Services has a copy of any relevant management plans to help me manage.

Functional Requirements

Activity	Tick one	Domestic and personal care	Provide details of the aids and assistance required, from whom and when
Housework	☐	Can maintain home without help (including laundry)	
	☐	Need some assistance (cleaner, change light bulb)	
	☐	Completely unable to do housework	
Transport	☐	No help needed (drives own car, or travels independently on public transport or by taxi)	
	☐	Need some help (someone to drive or accompany when travelling)	
	☐	Can only travel in specialised vehicle	
Shopping (has transport)	☐	Can take care of all shopping needs on own (including internet shopping)	
	☐	Need some help (someone to accompany on most shopping trips)	
	☐	Completely unable to do any shopping	

Meal preparation	☐	No help needed (can plan, prepare, cook and ensure nutrition)	
	☐	Need some help	
	☐	Completely unable to prepare meals and manage nutrition	
Eating	☐	No help needed	
	☐	Some help needed (cutting up food, spreading butter, pouring drink, modified cutlery)	
	☐	Completely unable to eat without help (spoon feeding)	
Taking oral medication	☐	No help needed (right dose and right time)	
	☐	Need some help (someone prepares, reminds, pre-packed)	
	☐	Completely unable to take own medicines without help	
Handling money	☐	No help needed (banking, paying bills, keeping track of finances)	
	☐	Need some help (can manage day to day buying but needs help with paying bills)	
	☐	Completely unable to manage money	
Telephone	☐	No help needed (can make and receive phone calls including using assistive devices)	

	☐	Needs some help	
	☐	Completely unable to use telephone	
Mobility	☐	No help needed (except use of stick)	
	☐	Need some help (person, walker, crutches or self-propelled wheelchair including cornering)	
	☐	Completely unable to walk or needs to be pushed in wheelchair	
Transfers Bed/chair	☐	No help needed	
	☐	Need some help (person or equipment)	
	☐	Unable to manage (unable to balance while sitting)	
Bathing Showering	☐	No help needed (get in and out of bath/shower and wash unaided)	
	☐	Need some help (rails, shower chair, person to shampoo hair) but can wash themselves	
	☐	Completely unable to bathe/shower on own	
Oral care	☐	No help needed (includes using electric toothbrush)	
	☐	Need some help (prompting)	

	☐	Completely unable to manage mouth care and cleaning teeth	
Dressing	☐	No help needed	
	☐	Need some help (zips, buttons, laces but can put on some garments)	
	☐	Completely unable to dress	
Grooming (makeup, hair, nails, shaving)	☐	No help needed	
	☐	Need some help	
	☐	Completely unable to manage any grooming without help	
Toileting	☐	No help needed (can get on and off, remove clothing and clean thoroughly)	
	☐	Need some help	
	☐	Completely unable to manage toileting without help	

Health requirements

Activity	Tick (as applicable)		Outline condition, treatments, aids/assistance required, from whom and when
Medical	☐	Have had a GP check up in the last 12 months	
	☐	See a specialist regularly	
	☐	Have a case manager/support coordinator	
Vaccinations	☐	Vaccinations have been up to date and all existing documentation regarding vaccination is obtained	
	☐	No written record of vaccinations (in which case, catch-up immunisation is recommended)	
	☐	Immunisations booked	Provide dates of scheduled vaccinations:
Dental	☐	Have had a dental check up in the last 12 months	

	☐	See a dentist regularly	
	☐	Dental check booked	Provide dates of scheduled dentist appointment:
Allied Health	☐	Have had an allied health check up in the last 12 months by a physio, occupational therapist, psychologist or other allied health practitioner	Provide details:
	☐	See an allied health practitioner regularly	
	☐	Allied health practitioner booked	Provide details of the allied health practitioner and dates of bookings:
Continence	☐	Continent with regular bowel and bladder action	
	☐	Constipation, diarrhoea or incontinence (using medication, supplements, pads)	
	☐	Medical interventions (catheter, stoma bag)	

Skin Integrity	☐	No skin problems	
	☐	Some skin problems (rash, skin treatments)	
	☐	Pressure areas (currently have, at risk, or had in past)	
Swallowing	☐	No swallowing issues	
	☐	Some swallowing problems (choking, coughing during normal meal, reduced appetite)	
	☐	Major swallowing difficulties (modified diet, feeding tube)	
Muscular pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	
Nerve pain	☐	No pain	
	☐	Moderate pain	
	☐	Severe pain	

Falls	☐	No falls in past 12 months	
	☐	Less than 3 falls and no serious injury from a fall in past 12 months	
	☐	More than 3 falls or a serious injury from a fall in the past year	
Muscular issues (other than pain)	☐	No problems	
	☐	Some muscle weakness, tremor, spasms, spasticity or problems with balance	
	☐	Serious muscle weakness, tremor, spasticity or problems with balance	
Other health concerns	☐	Fatigue	
	☐	Visual disturbance	
	☐	Temperature intolerance	
	☐	Other comorbidities	

Social Requirements

Activities	**Outline how you want to do this activity**	**Provide details of the activity, the time spent, the assistance required, from whom and when (including vouchers)**

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Example: I love cooking	• I like to watch cooking shows on TV • I like to buy good cook books • I like to prepare my own meals • I like to attend cooking classes regularly	• I need a TV in my room with good reception. • I need a computer/tablet and high speed internet or Wi-Fi to buy books online. • I would like to have access to a kitchen to prepare my own meals 2 x per week • I need a maxi taxi and carer/staff member to take me to cooking classes once a month
Family:		
Hobbies & Interests:		
Religion & spirituality		
Outings: E.g. theatre, cafes, exhibitions, drives, group activities		
Computer: E.g. games, shopping, education, bookings		
Employment: Education, Volunteering		
Sports:		
Music: Likes, dislikes		
Movies/TV:		

Likes, dislikes		
Well-being: E.g. exercise, gym, swimming, massage, yoga, meditation etc...		
Food and alcohol: Likes, dislikes, diets		
Sex and intimacy		
Other:		

Behavioural requirements

Issue	Tick one	Assistance I need	Outline the issue, aids, assistance and management strategies required

Communication	☐	No assistance required (including independent use of aids and adaptive technology)	
	☐	Some assistance required (prompting, assistance with aids)	
	☐	Assistance always required	
Memory problems Confusion	☐	No	
	☐	Yes	
Concentration problems	☐	No	
	☐	Yes	
Planning problems	☐	No	
	☐	Yes	
Spiritual needs	☐	No	
	☐	Yes	
Mood	☐	Mostly positive	
	☐	Experience sadness, anxiety or emptiness around 50% of time	

	☐	Feelings of anxiety, sadness or emptiness lasting most of the day, nearly every day	
Decision Making	☐	No help needed	
	☐	Need some help	
	☐	Not able to make any decisions	
Do you have a will?	☐	No	
	☐	Yes	
Do you have an Enduring Power of Attorney or Guardian?	☐	No	
	☐	Yes	
Do you have an Advance Care Plan?	☐	No	
	☐	Yes	

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What things are important for people to understand about you when caring for you?	Provide details	Outline how you like this to be managed
Who makes the decisions?		
What routines do you have?		
What makes you happy?		
What helps you relax?		
What causes you stress?		
What makes you frustrated?		
What makes you angry?		
Other		

Matching

We recognise the significance of matching the right staff member to meet your needs and consider a number of factors such as personality, language, culture and skill requirements. We encourage and support you to be involved in the process of matching your needs with the right staff. We can also support you to access an advocate of your choice to support you in this process.

Based on the above, what characteristics would you like to see in any staff member supporting you?	**Provide details**	**Notes in relation to potential Workers discussed with client who could provide supports (given preferences below and relevant training of Workers to deliver such supports)**
Gender	☐ Male ☐ Female ☐ No preference	
Personality type		
Languages spoken		
Culture or religion		
Specific needs, skills and knowledge required		
Intrusive support?		
Where the Client has specific needs which require monitoring and/or daily support, which Workers are appropriately trained to understand the Client's needs and preferences.		

What specific training may be required for this Client?		
Do the contemplated Workers that are proposing to provide these supports have such training?		
 **Conclusion: About your support worker**	Their name is: *Photo of Worker to be affixed here*	A bit about them:

Consent, internal checks and administrative requirements

Has the Clinical Risk Assessment and Safety Plan been completed with the Client?	☐	No (if no, provide details)	
	☐	Yes If yes, when (must be done regularly and at a minimum, at the same time as this support plan)	

Has the WHS Walk Around Risk Assessment been completed with the Client?	☐	No (if no, provide details including as to when it is scheduled)	
	☐	Yes	
Is the Client Intake Form,Risk Assessment Form, WHS Walk Around Risk Assessment and Services Agreement consistent with this Support Plan?	☐	No (if no, provide details)	
	☐	Yes	
Has the Privacy Consent Form been completed?	☐	No (if no, provide details)	
	☐	Yes (if yes, provide details if Hope Health & Care Services is not entitled to use or share personal information)	

In the event of an emergency or if your regular Worker is absent, do you consent to us finding a suitably qualified and/or experienced Worker at Hope Health & Care Services to fill in on a temporary basis to provide support to you?	☐	No (if no, provide details)	
	☐	Yes	
In the event of an emergency, do you consent to us engaging an external agency (such as Drake or Mabel) to provide short term assistance	☐	No (if no, provide details)	
	☐	Yes	

or otherwise recruit for the role.			
In the event of an unplanned absence becoming permanent, do you consent to us engaging a new Worker to act in the role permanently?	☐	No (if no, provide details)	
	☐	Yes	
Does the regular Worker understand these arrangements?	☐	No (if no, provide details)	
	☐	Yes	
Do you wish for information on your support plan to be communicated to family members, carers, other providers and relevant	☐	No (if no, provide details)	
	☐	Yes	

government agencies?			
Has this support plan been stored in a place which is readily accessible to the Client?	☐	No (if no, provide details)	
	☐	Yes	
Has this support plan been stored in a place which is readily accessible to {{Business Name}}?	☐	No (if no, provide details)	
	☐	Yes	
Has an emergency plan been prepared for this client?	☐	No (if no, provide details)	
	☐	Yes	

Please sign below to indicate your consent to the Client Support Plan:

Hope Health & Care Services ABN 52 655 753 352
Client Support Plan
Signed for and on behalf
of **Hope Health & Care Services Pty Ltd**
ABN 52 655 753 352 (Hope Health & Care Services), by:

.....
Signature

.....
Name (please print)

.....
Date

Signed by the **Client**:

.....
Signature

.....
Name (please print)

.....
Date

Hope Health & Care Services ABN 52 655 753 352
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Signed by the **Representative**:

.....
Signature

.....
Name (please print)

.....
Date

Signed for and on behalf
of **the Client's Worker**, by:

.....
Signature

.....
Name (please print)

.....
Date

Signed by an **interpreter**:

.....
Signature

.....
Name (please print)

.....
Date