GALLAWAH
~ Empowering Change ~

Kinaway CERTIFIED

GALLAWAH PARTICIPANT INTAKE FORM

1. Participant Details

Participant Name		D.O.B		Gender	
Contact details	Home		Mobile		
Email address					
Language spoken at home:		Interpreter required	❒ Yes ❒ No		
Preferred option for communication	❒ Email ❒ Post ❒ Phone		Do you identify as Aboriginal and Torres Strait Islander? ❒ Yes ❒ No		
Residential Address:					
Postal Address (if different from above)					

Is there a Guardianship and/or Administration order in place? ❒ Yes ❒ No

For participants under the age of 18 years of age, under guardianship or in the care of family or caregivers please complete below.

Name of Parent/Guardian 1		Primary Carer	❒ Yes	❒ No
		Lives with Participant	❒ Yes	❒ No
		Emergency Contact	❒ Yes	❒ No
Relationship to participant	❒ Parent ❒ Guardian ❒ Caregiver ❒ Other			
Residential Address:				
Postal Address (if different from above)				
Contact details	Home		Mobile	
Email address				

Name of Parent/Guardian 2		Primary Carer	❒ Yes	❒ No
		Lives with Participant	❒ Yes	❒ No
		Emergency Contact	❒ Yes	❒ No
Relationship to participant	❒ Parent ❒ Guardian ❒ Caregiver ❒ Other			
Residential Address:				
Postal Address (if different from above)				
Contact details	Home		Mobile	
Email address				

2. Disability / Medical Conditions including any diagnosis if relevant.

1.
2.
3.

Other service providers you are currently using:

Name		
Address		
Phone number/email		
Frequency of use:		

Name	
Address	
Phone number/email	
Frequency of use:	

Name	
Address	
Phone number/email	
Frequency of use:	

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3. Health Care Information

<table>
<tr><td rowspan="2">Medicare Number</td><td rowspan="2"></td><td>Expiry Date:</td><td></td></tr>
<tr><td>Reference Number:</td><td></td></tr>
<tr><td rowspan="2">Private Healthcare Provider</td><td rowspan="2"></td><td>Membership Number</td><td></td></tr>
<tr><td>Reference Number</td><td></td></tr>
</table>

Doctor Name	
Address	
Phone Number	

4. Funding

❐ NDIS Managed (A copy of the NDIS plan MUST BE provided for NDIA managed participants)

NDIS Number:	
NDIS Date:	

❐ Self-Managed ❐ Plan-Managed

Please provide details for invoices:

Name	
Email	
Comments	

5. Preferences

Preferred name	
Religious Requirements	
Cultural Requirements	
Communication device	
Physical Assistance	
Other Considerations	

6. Goals and Aspirations

What do you want to achieve for yourself – life skills, physically, socially etc?	
Immediately	
In 6 months	
Next year	

I understand that:

- These records are owned by this organisation.
- Information within these records will be shared with other staff within the organisation on and only when staff require the information to carry out their duties.
- I can ask to see records and receive a copy.
- Records are archived for a set period according to policy and procedure.
- I understand that all information obtained will be kept confidential.

To the best of my knowledge, the information provided in this form is true and correct:

Signature of Participant or Parent/Caregiver: ________________________________

Name: ______________________________________ Date: _______________

Relationship to participant: ______________________________*(if parent/caregiver)*

Gallawah Supports and Services

Please email completed intake form to supports@gallawah.com.au

Office number 03 4819 7270

Address: 51 Edward Street Shepparton 3630