Understand functional capacity assessments

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to understand:

- a functional capacity assessment
- the purpose of a functional capacity assessment
- the difference between a new and manual assessment
- what to do before completing a new assessment
- completing a new assessment.

1 Recent updates

July 2023 Update to system steps and language to align with PACE and knowledge consistency

2 Understand and record a functional capacity assessment

Understand functional capacity assessments

A functional capacity assessment is how we assess the impact a person's disability or a child's developmental delay has on their daily activities. Depending on their developmental delay or disability, the type of functional capacity assessment that we complete may vary.

The purpose of a functional capacity assessment

Functional capacity assessments are a form of evidence. We use them to understand the needs of a person. We complete this assessment to:

- help us identify the level of support and funding they will need in their plan
- understand how they manage everyday activities
- assist us in making decisions.

Partners can also use this information to understand the person's situation. This helps them to support the person to connect with the right supports.

New assessment and manual assessment

A new assessment refers to you completing a new PEDI-CAT or WHODAS assessment in PACE. To learn more, go to articles:

- Record assessment – PEDI-CAT
- Record assessment – WHODAS.

A manual assessment refers to any previously completed functional capacity assessments. For example, a person might give you a report from their doctor. You will enter the scores from the report in PACE.

The participant, their nominee or child representative, or their treating health professional can provide the score of an external assessment.

Before completing the assessment

Before completing the assessment, check for any exceptions, including:

- if the person does not want to complete assessment
- if the person has a priority situation
- if there are any identified risks
- if they have reapplied within the last 6 months.

When contacting an applicant, participant, their provider, or authorised representative, you must:

- check their preferred communication method and authorisations
- **log an activity**.

Read the articles:

- **Checking and updating a participant's preferred communication method**
- **Using the activity panel for logging an activity or internal note.**

Complete a new assessment

You need to make the person feel comfortable when communicating. When you are talking to them face to face or over the phone, make sure you:

- prepare for the conversation
- understand the person-centred approach
- understand the question you are asking
- tailor wording from assessment questions
- build rapport
- actively listen
- manage expectations with the individual that this does not mean they will get a funded NDIS plan.

For more information, go to the Conversation Style Guide.

To begin a functional capacity assessment, you must create a new **Functional Capacity Assessment** case. To do this, follow the steps in the article **Create a new functional capacity assessment case**.

Types of functional capacity assessments

There are many types of functional capacity assessments. We use them to help assess the level of impact a person's developmental delay or disability has on their lives.

For more information, go to articles:

General

- **Record information – life skills profile (LSP - 16)**
- **Record assessment – WHODAS**
- **Record assessment – PEDI-CAT**

Hearing loss

- **Record information – Functional Impact of Hearing Loss**

Vision loss

- **Record Information – Functional Impact of Vision Loss**

Spinal Injury

- **Record Information – Level of Lesion**

Traumatic brain injury

- **Record information – The care and needs scale**

Intellectual and development disability

- **Record information – Vineland**
- **Record information from the DSM5 – Autism**
- **Record information from the DSM5 – intellectual disability**

Cerebral palsy

- **Record gross motor functional classification scale**
- **Record information – Manual Ability Classification System.**
- **Record a communication function classification score**

Multiple Sclerosis

- **Record information – Disease Steps assessment**
- **Record information – Expanded Disability Status Scale**

Stroke / Neurological disability

- **Record information – Modified Rankin Scale**

3 Next steps

1. Read the article, **Create a new functional capacity assessment case**.

Create a new functional capacity assessment case

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This article provides guidance for a **local area coordinator, early childhood partner** and all NDIA staff (**planner delegate, payments officer, internal review delegate, complaints officer, participant support officer, access delegate, technical advisors, National Contact Centre, liaison officers (HLO/JLO), complex support needs (CSN) planner, national reassessment delegate**) to:

- create a new functional capacity assessment case.

1 Recent updates

December 2023

- Current guidance with updated PACE steps that include process steps to create a new functional capacity assessment case
- Article split from existing article Understand functional capacity assessments with information consolidated and removal of redundant and common capability content.

2 Before you start

You have:

- read article Understand functional capacity assessments
- read Our Guidelines – Applying to the NDIS, including section **Does your impairment substantially reduce your functional capacity?**
- read article How to apply for the NDIS in PACE to understand when during the application process you need to create a new functional capacity assessment case
- discussed with the applicant the daily impact their disability has on them, to decide the type of assessment that will best suit their support needs.

3 Create a new functional capacity assessment case

1. From the **Person Account**, in account view, select **Cases** tab.
2. Select **New** in the top-right corner of the cases panel.
3. Select **Functional Capacity Assessment**.
4. Select **Next**.
5. In **Categorisation** section, select **Origin**.
6. Select **Save**.
7. From the functional capacity assessment view, select **Assessment** tab.
8. Review the details before proceeding.
9. Select **Next**.
10. Select **Yes** or No for an authorised representative.
11. Select **Next**.

The next steps will depend on the **type** of **functional capacity assessment** you need to complete or record.

4 Next steps

1. Determine from your discussion with the applicant, if a new or manual assessment is required. For more information on assessment types, refer to article Understand functional capacity assessments.
2. Then select the article for the relevant assessment you will complete:
    - **New assessment**
        - Record assessment – WHODAS
        - Record assessment – PEDI-CAT
    - **Manual assessment**
        - Record information - life skills profile (LSP - 16)
        - Record information – functional impact of hearing loss
        - Record information – functional impact of vision loss
        - Record information - level of lesion
        - Record information - the care and needs scale
        - Record information – Vineland Adaptive Behaviour scales
        - Record information from the DSM5 – Autism
        - Record information from the DSM5 – intellectual disability
        - Record gross motor functional classification scale
        - Record information - Manual Ability Classification system
        - Record a communication function classification score
        - Record information - disease steps assessment
        - Record information - expanded disability status scale
        - Record information - Modified Rankin scale

Record assessment - WHODAS

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This article provides guidance for a **local area coordinator, early childhood partner** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand a WHODAS assessment
- prepare for a new assessment
- complete the WHODAS assessment.

1 Recent updates

October 2023

Current guidance.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the article Understand functional capacity assessments
- read the article **Create a new functional capacity assessment case.**

3 Understand and complete a WHODAS assessment

Understand a WHODAS assessment

The World Health Organisation Disability Assessment Schedule (WHODAS) is a series of questions for people 17 years of age and above. It assesses the individual's difficultly completing or undertaking tasks in different areas of their life. It helps us to understand the level of difficulty an individual experiences when doing different activities.

We complete the WHODAS assessment when we have no recorded evidence of other functional capacity assessments on file. We record the level of difficulty the participant has found when completing tasks in the past 30 days.

Prepare for a new assessment

Make the person feel comfortable when communicating. When you are talking to them face to face or over the phone, make sure you:

- tailor wording from assessment questions
- understand the question you are asking
- understand the person-centred approach
- prepare for the conversation
- build rapport
- actively listen
- manage expectations with the individual that this does not guarantee a funded NDIS plan.

For more information, go to the Guide = Conversation style guide.

When contacting an applicant, participant, their provider, or authorised representative, you must:

- check their preferred communication method and authorisations
- log an activity.

Read the articles:

- Check a participant's preferred communication method
- Log an activity or internal note.

Complete the WHODAS assessment

To complete the WHODAS assessment in PACE:

At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **Yes** to **Carry out a new assessment**.
2. Select **WHODAS 12**.
3. Select **No** to **Manually enter scores**.
4. Select **Next.**
5. Ask the participant the questions listed. Move the sliding scale indicator to a score between 1 and 5. Answer each question using the provided scale explanation at the top of the screen.
6. Select **Next.**

7. Check the **Confirmation** details.
8. Select **Done**.

4 Next steps

There are no further steps.

Record assessment - PEDI-CAT

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand a PEDI-CAT assessment
- understand the difference between a new assessment and manually entered score
- complete a new PEDI-CAT assessment
- record a manual PEDI-CAT assessment.

1 Recent updates

18 December 2023

Update to include the transfer of work instruction on PACE for PEDI-CAT domain manual score entry.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the articlehttps://ndia.my.salesforce.com/articles/Knowledge/230180907Understand functional capacity assessments
- read the article Create a new functional capacity assessment case.

3 Understand and record a PEDI-CAT assessment

The PEDI-CAT assessment

A PEDI-CAT assessment helps us understand a child's ability to complete tasks in their daily life.

We use the PEDI-CAT assessment with children younger than 6. Sometimes, we use PEDI-CAT for children aged 7-16 if there isn't another tool available.

The difference between a new assessment and manually entered score

You complete a **New** PEDI-CAT assessment in PACE. You begin by creating a new **Functional Capacity Assessment** case. PACE will direct you to an external Pearson site. Pearson will automatically populate a score based on answers to the questions.

A **Manual** PEDI-CAT assessment is one completed outside of Pearson. You will enter the score in PACE. For example, a parent might give you a PEDI-CAT assessment from their child's doctor.

Note: If you receive a PEDI-CAT assessment score from within the last 3 months, use this to update the manually entered score. If the PEDI-CAT assessment score is from more than 3 months ago, use Pearson to get a new assessment score.

Complete a new PEDI-CAT assessment

To record a **New** PEDI-CAT assessment, complete the following PACE steps.

From the functional capacity assessment view:

1. Select **Yes** to **Carry out a new assessment**.
2. Select **No** to **Manually enter scores**.
3. Select **PEDICAT or PEDICAT-ASD**.
4. Select **Next.**
5. Confirm details are correct.
6. Select **Launch PEDI-CAT** to open in Pearson.
7. Complete online PEDI-CAT assessment.
8. Once completed, return to PACE and select **Check status** to refresh.
9. Select **Save for later** or **Next**.
10. Check confirmation details.
11. Select **Done**.

Note: Don't open a new assessment if you do not intend on completing it that day.

Record a manual PEDI-CAT assessment

To record a manual PEDI-CAT assessment, complete the following PACE steps.

At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores.**

3. Select **PEDICAT or PEDICAT ASD.**
4. Select **Next.**
5. Enter **Assessment completion date**.
6. Enter all **Domain Scaled Scores.**
    - Add the numerical scores into the domain fields.**Note**: For children younger than 3 years, record the **PEDI-CAT Responsibility Domain** as 0. This is because domain scaled scores are not completed for children younger than 3 years old.
7. Enter all **Domain T Scores.**
    - When the T score generates and displays as **less than 10**, record the score as 1 in PACE.
    - When the T score generates **greater than or equal to 10**, record the exact score in PACE.**Note**: For children younger than 3 years, record the **PEDI-CAT Responsibility Domain** as 0. This is because domain T scores are not completed for children younger than 3 years old.
8. Enter all **Domain Age Percentiles**.

Note: This score will show as either an exact number or a percentile band dependent on version used.

- If **exact score**, enter as displayed.
- When the age percentile generates and displays as **less than the 5th percentile**, record the score as 1 in PACE.
- For **age percentile 5 to 25**, record the lower percentile (5) or the number displayed.
- For **age percentile 25 to 50**, record the lower percentile (25).
- For age **percentile 50 to 75**, record the lower percentile (50).
- For age **percentile 75 or above**, record 75.
  Note: For children younger than 3 years, record the PEDI-CAT Responsibility Domain as 0. This is because domain age percentiles are not completed for children younger than 3 years old.

9. Select **Next**.
10. Check the **Confirmation** details. Select **Done**.

4 Next steps

There are no further steps.

Record a communication function classification score

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the communication function classification score (CFCS)
- record information from the CFCS.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case**.

3 Understand the communication function classification score

The communication function classification (CFCS) score is a 5-level classification tool. It measures the level of support a person needs. We use the communication function classification score for people with cerebral palsy. An allied health professional completes the assessment.

You enter the assessment score in PACE.

4 Record information from the CFCS

To record results of a CFCS, complete the following steps at the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Communication Function Classification Score (CFCS)**.
4. Select **Next.**
5. Enter **Assessment completion date.**
6. Select **Score or rating**.
7. Select **Next.**
8. Check the **Confirmation** details.
9. Select **Done**.

5 Next steps

There are no further steps.

Record Information - Disease steps assessment

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This article provides guidance for a l**ocal area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support)** to:

- understand a disease steps assessment
- record information about disease steps

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read article **Understand functional capacity assessments**
- read article **Create a new functional capacity assessment case.**

3 Understand and record disease steps assessment

Understand a disease steps assessment

The disease steps classification scale assesses the level of impact multiple sclerosis has on the participant's daily activities. We use this where they have identified multiple sclerosis as their primary disability.

To do a multiple sclerosis assessment, use one of these sources in preference order:

- **Disease steps**: for all ages – provided by a medical professional or equivalent.
- **Multiple sclerosis severity tool:** for all ages - Patient Determined Disease Steps (PDDS), available on the NDIS intranet. Provided by a medical professional or equivalent or completed internally.
- **Expanded Disability Status Scale (EDSS)**: for all ages – provided by a medical professional or equivalent. To learn more, go to article **Record information – Expanded disability status scale.**

Note: Evidence from a treating health professional should be from a neurologist or a disease steps trained nurse examiner.

Disease steps overall score or rating

The below descriptions are from published research developed by Hohol et al. (1995):[1]

- **Level 0** - **Normal**: functionally normal with no limit on activity or lifestyle.
- **Level 1** - **Mild disability**: mild symptoms or signs.
- **Level 2** - **Moderate disability**: the main feature is a visible abnormal gait. Patients do not require ambulation aids.
- **Level 3** - **Early cane**: intermittent use of cane (or other forms of unilateral support including splint, brace, or crutch).
- **Level 4** - **Late cane**: these patients are dependent on a cane or other forms of unilateral support. They cannot walk 7.6 metres without such support
- **Level 5** - **Bilateral support**: patients require bilateral support to walk 7.6 metres. For example, two canes, two crutches or a walker.
- **Level 6** - **Confined to wheelchair:** patients confined to a wheelchair or scooter.

This scale can also provide an '**unclassifiable**' category for patients who do not fit the above categories.

For example, patients who are otherwise minimally impaired but have:

- significant cognitive or visual impairment
- overwhelming fatigue

- significant bowel or bladder impairment.

Record information about disease steps

At the **Select Tools** step of the **Functional Capacity Assessment** in PACE:

1. Select **No** to **Carry out a new assessment.**
2. Select **Yes** to **Manually enter scores**.
3. Select **Disease steps**.
4. Select **Next**.
5. Record the **Assessment completion date**.
6. Record the score at **Please enter the overall score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details
9. Select **Done**.

4 Next steps

There are no further steps.

[1] Hohol MJ, Orav EJ, Weiner HL. Disease steps in multiple sclerosis: a longitudinal study comparing disease steps and EDSS to evaluate disease progression. Mult Scler. 1999 Oct;5(5):349-54

Record information - Expanded Disability Status Scale

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support)** to:

- understand the Expanded Disability Status Scale
- record information about Expanded Disability Status Scale.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read article **Understand functional capacity assessments**
- read article **Create a new functional capacity assessment case**.

3 Understand and record an Expanded Disability Status Scale assessment

Understand the expanded disability status scale

The expanded disability status scale (EDSS) is a scale from 0 to 10:

- 0 = no impairment
- 10 = the greatest severity.

It measures disability in multiple sclerosis and monitors the change in the level of disability over time.

It has a wide use in clinical trials and in assessing people with multiple sclerosis. It is based on published research developed by John Kurtzke in 1983. [1]

To complete a multiple sclerosis assessment, use one of these sources in preference order:

- **Disease steps**: for all ages – provided by a medical professional or equivalent. To learn more, go to article **Record information – disease steps assessment.**
- **Multiple sclerosis severity tool**: for all ages – patient determined disease steps (PDDS), available on the NDIS intranet. Provided by a medical professional or equivalent or completed internally.
- **Expanded Disability Status Scale (EDSS)**: for all ages – provided by a medical professional or equivalent.

Note: Evidence from a treating health professional should be from a neurologist or a disease steps trained nurse examiner.

4 Record EDSS information

To record results of an EDSS assessment, complete the following steps in PACE:

At the **Select Tools** step in the **Functional Capacity Assessment:**

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Expanded Disability Status Scale**.
4. Select **Next**.
5. Record **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

5 Next steps

There are no further steps.

[1] Kurtzke JF. Rating neurological impairment in multiple sclerosis: an expanded disability status scale (EDSS). Neurology. 1983;33(11):1444-1452

Record information - functional impact of hearing loss

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand a functional impact of hearing loss assessment
- record a hearing loss assessment in PACE

1 Recent updates

July 2023 Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case.**

3 Understand and record a functional impact of hearing loss assessment

The functional impact of hearing loss assessment is a 10-point scale that evaluates a participant's hearing. The scale uses questions that require **yes, no, almost always, sometimes**, and **rarely** answers.

From the results of these questions, the assessor will work with the person. They will read a number of statements. They will then choose which statement best describes the person's impact of hearing loss.

Completion of the assessment can be:

- by an allied health professional
- done internally. It is available on the NDIS intranet.

You will enter the results into PACE.

Record a functional impact of hearing loss assessment

To enter a score of a functional impact of hearing loss assessment, complete the following steps in PACE:

At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Functional Impact of Hearing Loss**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information – functional impact of vision loss

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the functional impact of vision loss assessment
- record information from the functional impact of vision loss assessment.

1 Recent updates

July 2023

Expanded definition of functional impact of vision loss assessment.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case**.

3 Understand and record the functional impact of vision loss assessment

Functional impact of vision loss assessments help us to understand how a person's vision loss affects their daily life. The assessor asks the person a series of questions. They then select statements to best describe the impact.

Completion of the assessment can be:

- by an allied health professional
- done internally. It is available on the NDIS intranet.

You will enter the results into PACE.

Record information from the functional impact of vision loss assessment

To record a functional impact of vision loss assessment, at the **Select Tools** step in the **Functional Capacity Assessment:**

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Functional Impact of Vision Loss**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information – Gross Motor Functional Classification Scale

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the Gross Motor Functional Classification Scale (GMFCS)
- record information from the GMFCS assessment.

1 Recent updates

July 2023 Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case.**

3 Understand and record the Gross Motor Functional Classification Scale

The Gross Motor Functional Classification Scale (GMFCS) is a 5-level categorical scale. We use it to measure the level of support a person needs. We use the GMFCS for children and adolescents with cerebral palsy.

Completion of the assessment can be:

- by an allied health professional
- done internally. It is available on the NDIS intranet.

You will enter the results into PACE.

Record information from the GMFCS assessment

To enter the score of a GMFCS assessment in PACE, complete the following steps:

At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Gross Motor Functional Classification Scale (GMFCS)**.
4. Select **Next.**
5. Enter **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next.**
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information - level of lesion assessment

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This article provides guidance for a **local area coordinator**, **early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand a level of lesion assessment
- record information about level of lesion in PACE.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the article **Understand functional capacity assessments**
- read the article **Create a functional capacity assessment case**.

3 Understand and record a level of lesion assessment

A level of lesion assessment helps identify the injured vertebrae related to a spinal injury. This usually follows a traumatic injury from situations such as a:

- diving accident
- horse riding accident
- car, motorbike, or other vehicle accident.

An allied health professional completes the assessment. You will enter the assessment score in PACE.

Level of lesion sections

The level of lesion assessment groups vertebrae into sections. The higher the injury on the spinal cord, the more dysfunction can occur for the person. These sections are:

- high cervical nerves (C1 – C4)
- low cervical nerves (C5 – C8)
- thoracic nerves (T1 – T12)
- lumbar nerves (L1 – L5)
- sacral nerves (S1 – S5).

Record level of lesion information

To enter a level of lesion assessment, at the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Level of Lesion**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done.**

4 Next steps

There are no further steps.

Record information – Life Skills Profile (LSP - 16)

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the life skills profile (LSP - 16)
- record LSP - 16 information in PACE.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case**.

3 Understand the life skills profile (LSP - 16)

The life skills profile considers areas such as social relationships, and an individual's ability to complete day-to-day tasks. Its focus is on the person's general functioning and disability, rather than their symptoms.
The four sub-scales in the LSP-16 are:

- withdrawal
- self-care
- compliance
- anti-social behaviour.

The total score can range from 0 to 48, increasing with the severity of the impact of the disability.

An allied health professional will complete the assessment. You will enter the received assessment score in PACE.

4 Record LSP-16 information in PACE

To record an LSP-16 assessment, complete the following PACE steps at the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment.**
2. Select **Yes** to **Manually enter scores**.
3. Select **Life Skills Profile (LSP-16)**.
4. Select **Next**.
5. Enter **Assessment completion dat**e.
6. Enter **Score**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

5 Next steps

There are no further steps

Record information – Manual ability classification system

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the manual ability classification system
- record a manual ability classification assessment in PACE.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case**.

3 Understand and record the manual ability classification system

The manual ability classification system is a way to measure a person's ability to complete tasks in daily life. It categorises the ability of people to handle objects in everyday life into five levels. An allied health professional completes the assessment. You enter the details into PACE.

Record a Manual Ability Classification assessment in PACE

To record a manual ability classification assessment, at the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment.**
2. Select **Yes** to **Manually enter scores**.
3. Select **Manual Ability Classification System (MACS)**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information - Modified Rankin Scale

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This article provides guidance for a **local area coordinator**, **early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the Modified Rankin Scale
- record a Modified Rankin Scale in PACE.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency

2 Before you start

You have:

- read article **Understand functional capacity assessments**
- read article **Create a new functional capacity assessment case**.

3 Understand and record the Modified Rankin Scale

The Modified Rankin Scale is a seven-point mobility scale that evaluates a person's mobility. This is for people who have suffered a stroke or other neurological disability. The scale is based on **yes** or **no** answer questions, which will generate a score.

An allied health professional completes the assessment when someone is wanting to apply. This helps us understand their situation and the supports they need.

Record a Modified Rankin Scale in PACE

To record a Modified Rankin scale assessment, at the Select Tools step in the Functional Capacity Assessment:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Modified Rankin Scale**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information – the Care and Needs Scale

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the Care and Needs Scale
- record information from the Care and Needs Scale.

1 Recent updates

July 2023

Updated to align with current steps in PACE.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read article **Understand functional capacity assessments**
- read article **Create a new functional capacity assessment case**.

3 Understand and record the Care and Needs Scale

We use the care and needs scale for people older than 16 years with traumatic brain injury. The scale has 8 categories to measure the support level a person needs. An allied health professional completes the assessment. You enter the assessment score in PACE.

Record the Care and Needs Scale information

To record a Care and Needs Scale assessment, at the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **The Care and Needs Scale (CANS)**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score or rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information - Vineland Adaptive Behaviour Scales

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This article provides guidance for a l**ocal area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand Vineland Adaptive Behaviour Scales second edition (Vineland 2)
- understand Vineland Adaptive Behaviour Scales third edition (Vineland 3)
- record a Vineland 2 or 3 assessment.

1 Recent updates

July 2023

Updated Vineland 2 and Vineland 3 definitions.

2 Before you start

You have:

- read Our Guidelines – Applying to the NDIS
- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case.**

3 Understand and record Vineland 2 and 3

Vineland measures a person's adaptive behaviour. It can be used for diagnosis support for individuals with intellectual, developmental, and other disabilities.

Vineland 2

Vineland 2 assesses the personal and social skills needed for everyday living.

It assesses many domains. It provides an overall adaptive behaviour composite. The four core Vineland 2 domains are:

- communication
- daily living skills
- socialisation
- motor skills.

Use the Vineland 2 assessment information the participant provides you with, and the table below. This will determine the adaptive behaviour composite score to record in PACE:

Category	Option in PACE
Profound	Adaptive behaviour composite 25 and below
Severe	Adaptive behaviour composite 26 - 40
Moderate	Adaptive behaviour composite 41 - 55
Mild	Adaptive behaviour composite 56+

Vineland 3

This is a revised third version of the Vineland 2. It provides an overall adaptive behaviour composite. The three core domains are:

- communication
- daily living skills
- socialisation.

Vineland 3 also offers optional motor skills and maladaptive behaviour domains for situations where these areas are of concern.

Record a Vineland assessment in PACE

An allied health professional will complete the assessment. You will enter the results into PACE.

Where a participant presents with a Vineland assessment, complete the following PACE steps:
At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment.**
2. Select **Yes** to **Manually enter scores**.
3. Select **Vineland 2** or **Vineland 3**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select or enter **Overall score or rating.**

Note: For **Vineland 2**, select the relevant score range from the dropdown. For **Vineland 3**, manually enter the score as a whole number, with no decimal places.

7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

4 Next steps

There are no further steps.

Record information from the DSM5 - Autism

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the DSM-5 assessment
- understand the DSM-5 – autism levels
- record the DSM-5 results.

1 Recent updates

July 2023 Update to system steps and language to align with PACE and knowledge consistency.

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case**.

3 Understand and record a DSM-5 assessment

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a diagnostic manual. Mental health professionals use it to diagnose and understand a range of diseases. This includes autism.

A medical professional must complete the DSM-5 autism spectrum disorder assessment.

To learn more about recording the DSM-5 for intellectual disability, go to **record information from the DSM5 – intellectual disability**.

The DSM5 – autism levels

A health professional determines the severity of autism using measures of social communication and of restrictive, repetitive behaviours.

The DSM-5 Autism assessment allocates a person's support needs into one of three levels:

- **Level 1 - Requiring support**
- **Level 2 - Requiring substantial support**
- **Level 3 - Requiring very substantial support.**

Record the DSM-5 results

Where a participant presents with a DSM-5 Autism assessment, complete the following PACE steps:

At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment**.
2. Select **Yes** to **Manually enter scores**.
3. Select **Diagnostic and statistical manual of mental disorders (DSM-5) Autism**.
4. Select **Next**.
5. Enter **Assessment completion date**.
6. Select **Score or Rating**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

Next steps

There are no further steps.

Record information from the DSM5 - Intellectual Disability

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This article provides guidance for a **local area coordinator, early childhood coordinator** and all NDIA staff (**planner, payment officer, internal review officer, complaints officer, participant service officer, access officer, quality officer, technical advisor, SDA officer, NCC officer, provider support**) to:

- understand the DSM-5 intellectual disability (ID) assessment
- the DSM-5 ID scale
- record the DSM-5 ID results.

1 Recent updates

July 2023

Update to system steps and language to align with PACE and knowledge consistency

2 Before you start

You have:

- read Our Guidelines – applying to the NDIS
- read the article **Understand functional capacity assessments**
- read the article **Create a new functional capacity assessment case.**

3 Understand and record a DSM-5 intellectual disability assessment

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is a diagnostic manual used by mental health professionals. They use it to diagnose and understand a range of diseases. This includes intellectual disability (ID).

A medical professional must complete the DSM-5 ID assessment.

To learn more about recording the DSM-5 for autism, go to **Record information from the DSM5 – autism**.

4 The DSM-5 ID scale

- The DSM-5 ID uses two measures:
- cognitive function (IQ)
- adaptive functioning.

It rates an individual by the following four-level scale:

- **Mild level 1**
- **Moderate level 2**
- **Severe level 3**
- **Profound level 4.**

5 Record the DSM-5 ID results

Where a participant presents with a DSM-5 ID assessment, complete the following PACE steps:

At the **Select Tools** step in the **Functional Capacity Assessment**:

1. Select **No** to **Carry out a new assessment.**
2. Select **Yes** to **Manually enter scores**.
3. Select **Diagnostic and statistical manual of mental disorders (DSM-5) ID.**
4. Select **Next.**
5. Enter **Assessment completion date.**
6. Select **Score**.
7. Select **Next**.
8. Check the **Confirmation** details.
9. Select **Done**.

6 Next steps

There are no further steps.

How to apply for the NDIS in PACE

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This article provides guidance for a local area coordinator, early childhood partner, planner delegate, liaison officers (HLO/JLO) and planner (non-partnered area) to:

- understand cases to complete when applying for the NDIS
- understand when an application can be prioritised
- understand who needs to provide evidence of identity
- identify possible integrity issues with an application
- know how to action an extra information privacy request
- know when to complete an assessment.

1 Recent updates

27 May 2024

- Included a note to detail the benefits of a community connections case
- Included reference to article **Log an activity or internal note** in section **Information: evidence, notes, and documents**.

6 May 2024

- Added guidance for cases that don't need to be completed for applicants through the terminal illness priority pathway.

2 Before you start

You have read and understood Our Guideline – Applying for the NDIS.

3 Cases to complete when applying for the NDIS

The following cases are **required** when applying for the NDIS:

- **Create Person Account**. Use article Create a person account
- **Streaming**. Use article Complete a streaming case (Streaming and Restreaming)
- **Access Request**. Use article Create an access request case.

You **must** also verify the applicant's identity, and their authorised representative's identity (if applicable). Use articles Understand how to verify identity documents and Upload evidence of identity documents.

3.1 Information gathering cases

Before you finalise the NDIS application, complete the following cases, unless there's a reason you can't:

- **Community Connections**. Use article Create and complete a community connections case.

Note: Information gathering as part of **community connections is important**. If they become eligible, the information in the community connections case will populate in their NDIS plan. You can complete a community connections case to record the information without needing to generate a community connections plan.

- **Update Person Account**. Use article Update a person account to update the person's details. Use article Add or cancel a relationship to add or cancel a relationship.
- **Manage authorised representative**. Use article Understand the articles to use for the Manage Authorised Representative case to add or cancel an authorised representative.
- **Personal and environmental circumstances**. Use article Create a new personal and environmental circumstances case.
- **Short Form Outcomes Framework named SFOF**. Use article Complete the Short Form Outcomes Framework (SFOF).
- **Functional capacity assessment**. Use article Create a new functional capacity assessment case.

If they're eligible, the information you gather will be used to inform their first plan.

Note: For applicants with terminal illness, don't complete cases for **Community Connections**, **Early supports**, **Participant environmental circumstances** (PEC), **Functional capacity assessment** (FCA), or **Short Form Outcomes Framework** (SFOF). This will help progress these applicants quickly.

3.2 Information: evidence, notes, and documents

You **must** include all notes and documents, including attachments and emails, in relevant cases and records. Learn more by reading articles:

- Add documents to a case
- Add and link evidence to a case
- Log an activity or internal note.

Check for an existing enquiry case for any access-related information and documents. This could also include an attached access request form (ARF).

3.3 Information: streaming

You **must** complete a streaming case **before creating an Access Request case**.

This is critical to make sure the Typical Support Package (TSP) is generated if the applicant is eligible, so they're assigned to the correct team. Use article Complete a streaming case (Streaming and Restreaming). A delegate will then approve or override the streaming request.

4 When can we prioritise an application?

4.1 Required priority evidence

An applicant needs to provide evidence of their situation. It'll need to match with at least one requirement for a priority eligibility decision.

The required evidence type will depend on each applicant's situation. Read article Request priority eligibility decision.

4.2 Priority application assessment

The Scheme Eligibility Branch will look at the request. If approved, they'll action the priority application within 2-5 business days. If declined, they'll contact the applicant within 21 days.

5 Who needs to provide evidence of identity?

Evidence of identity **must** be provided by:

- a person applying to be a participant
- an authorised representative for an applicant or participant (if applicable).

5.1 What documents can we accept as evidence of identity?

The applicant **must** provide evidence of **one** 'Birth or Arrival Document' and **at least two** 'Use in Community Documents'.

To learn more about identity documents, read Fact Sheet – Evidence of identity

To receive and upload identity documents, use articles Understand how to verify identity documents and Upload evidence of identity documents.

Note: Make sure you record the person's name who helps give documents. This will allow for a request for further information to be direct with the relevant person. For more information on how to record a person's name, read article Log an activity or internal note.

6 Identify possible integrity issues

You need to make sure that evidence of identity, age, residency, and disability information provided is genuine. For more information on how to identify an integrity issue, read article Understand how to verify identity documents.

7 Extra information privacy

A person may ask to have extra privacy for their information when they apply to the NDIS. This is called restricted access. Read article Understand restricted access.

8 When to do assessments?

With the applicant, complete the personal and environmental circumstances case and a functional capacity assessment. You should do this **before** you finalise their NDIS application.

9 Next steps

1. To start the application read article Create an access request case.
2. For more information about the community connections case and early supports, read articles:
    - Create and complete a community connections case
    - Create and complete an early supports plan.
3. For more information about assessments read articles:
    - Understand functional capacity assessments
    - Complete personal and environmental circumstances case
    - Complete the Short Form Outcomes Framework (SFOF).

Action a plan approval case when access is granted without pre-access information gathering

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This article provides guidance for a planner delegate to understand:

- a plan approval case with no pre-access information gathering
- gathering information about the participant
- when to update streaming and my NDIS contact.

1 Recent updates

12 August 2024
Guidance updated to mention the Plan Conversation Support Tool (PCST) must be used for all new plans and plan reassessments.

2 Before you start

You have received a plan approval case with no information included.

3 A plan approval case with no pre-access information gathering

Sometimes you'll receive a plan approval case to action where a community connection or early supports case was not needed and there's no information or only limited information included. This may result in a $0 typical support package (TSP). This can happen when an access request is managed through an alternate pathway such as SAP CRM or a Telephone Access Request (TAR). A Telephone Access Request can only be completed if the person applying meets certain criteria.

If the participant or their authorised representative completed a Telephone Access Request, you should read all notes in the **Log Activity** tab which will include text of **NCC TL TAR**.

If you identify a plan approval case doesn't have the information you need, speak with the participant or their authorised representative. This includes talking with the participant about their goals. You'll need to complete the personal and environmental circumstance case (PEC), functional capacity assessment (FCA) and short form outcomes framework (SFOF) to provide you with the information necessary to progress the plan approval case. You'll also need to check the streaming and my NDIS contact and update them if needed.

4 Gathering information about the participant

If you've identified the information hasn't been captured previously, you'll need to gather this before progressing with the plan approval case. Gather this information through a **Check-in** case, refer to article Create a check-in case. Complete the check-in process including recording the following information:

- **About Me**
- **Goals**
- **Informal, Community and Mainstream Supports**
- **Relationships**
- **Budget and funded supports**
- **Changes in situation**
- **Potential risks and vulnerabilities**
- **Next steps**.

In **Next Steps** you'll need to select **Complete Personal and environmental circumstance, Update functional capacity assessment** and **Complete SFOF**.
Refer to articles:

- Understand functional capacity assessments
- Complete personal and environmental circumstance case
- Complete the Short Form Outcomes Framework (SFOF).

Note: For participants younger than 7 years of age, when you complete the FCA you'll select PEDICAT to either complete a new PEDICAT or enter the score for a PEDICAT already completed. Refer to article, Record assessment – PEDI-CAT. When you complete the PEC, you'll need to refer to article EC – PEC General overview.

Once all needed information has been gathered and the check-in case is completed, you should progress with completing the plan approval case.

After all information is gathered the TSP will still not generate and you'll need to develop the participant's plan. Use the **Plan Conversation Support Tool** to help develop a budget that meets the participant's disability-related support needs. You **must** use the PCST for all new plans and plan reassessments and attach to the participant record. Go to article Understand and update the plan conversation support tool.

5 When to update streaming and my NDIS contact

If the information we need wasn't gathered prior to the participant meeting access, the participant's stream will be recorded Intensive or Super Intensive. You must check the participant's current stream. If the participant or their authorised representative completed a TAR and advised they don't want to work with a partner, their stream will need to stay as Intensive regardless of streaming factors, unless the Super Intensive streaming factors apply.

Note: You'll need to think about what level of support coordination funding to include in the plan based on the information you gathered in the check-in case and streaming factors that should apply.
If the participant or their authorised representative completed a TAR for another reason or access via SAP CRM, you should discuss linking the participant to a partner if this aligns to their correct streaming. The partner will help the participant with plan implementation and future check-ins. If you need to update the streaming refer to article, Complete a streaming case (Streaming and Restreaming).

You'll also need to check the participant's my NDIS contact and update if needed. Where the participant doesn't want to work with a partner, you should assign yourself as the my NDIS contact. Refer to article Update the my NDIS contact.

6 Next steps

1. Update the draft budget in the plan approval case, using article Change the draft budget.

Standard Operating Procedure

For Internal Use Only

The contents of this document are OFFICIAL.

Complete the Update the Severity Tools task

This Standard Operating Procedure (SOP) will support you to complete the Update the Severity Tools task in the NDIS Business System (System).

A functional capacity assessment is used to assess the level of impact the participant's disability has on their everyday activities. In the System we refer to functional capacity assessments as Severity Tools. The term **Severity Tool is for internal use**. It is best practice to use the more widely accepted term Functional Capacity Assessment when talking with the participant.

Note: The age range is changing for the NDIS early childhood approach. From July 1 2023, the age will change to include children younger than 9. The change will be rolled out over the next 2 years. Early childhood partners will need to use this resource to plan for children aged 7 or 8.

1. Recent updates

Date	What's changed
July 2023	Updates to support early childhood partners to plan for children aged 7 or 8.
May 2022	SOP update to confirm children aged 7-16 only need the PEDI-CAT assessment tool if a more appropriate tool cannot be recorded.
February 2021	New SOP format to align with Our Guidelines refresh. SOPs include process information only. Use Our Guidelines to help you make decisions and refer to Related procedures or resources. Additional updates: • The table for the American Spinal Injury Impairment Scale (ASIA) has been updated.

2. Checklist

Topic	Checklist
Pre-requisites	❑ The participant has met access to the NDIS. You have: ❑ read and understood Our Guideline – Creating Your Plan ❑ read and understood Our Guideline – Your Plan ❑ identified that you need to complete the update severity tools task because: ❑ The participant has met access requirements. ❑ There is a change in the participant's functional capacity. ❑ The participant has a degenerative condition such as Motor Neurone Disease where their functional capacity is likely to change, or an episodic condition like Psychosocial disability. ❑ The participant provides you with an updated functional capacity assessment. ❑ The participant is younger than 7 and needs a PEDI-CAT completed at each plan reassessment. ❑ The participant met access through early intervention and is having their plan reviewed. This includes adults and children. ❑ The participant's plan is being reviewed. The Update Severity Tools task or the WHODAS needs to be completed at plan review to generate a TSP. ❑ checked the participant's primary disability has been recorded correctly in the System and updated if needed. You are familiar with: ❑ Appendix 1: Tools for assessing a participant's functional capacity ❑ Appendix 2: Collecting functional capacity assessment score or level ❑ Appendix 3: Providing evidence of severity of disability ❑ Appendix 4: Overview of the create-Severity Scales Tools form

Standard Operating Procedure

For Internal Use Only

Topic	Checklist
Actions	This SOP is structured differently to other guidance documents. You only refer to the instructions for the participant's primary disability. Choose from: ❑ 3.1 Acquired Brain Injury ❑ 3.2 Autism ❑ 3.3 Cerebral Palsy ❑ 3.4 Developmental Delay (0-6 only) ❑ 3.5 Intellectual Disability, Global Developmental Delay (age 0-6 only) or Down Syndrome ❑ 3.6 Internal Agency Assessment Tool ❑ 3.7 Hearing ❑ 3.8 Multiple Sclerosis ❑ 3.9 Psychosocial disability ❑ 3.10 Spinal Cord Injury ❑ 3.11 Stroke ❑ 3.12 Vision ❑ 3.13 Other Primary Disability ❑ 3.14 PEDI-CAT ❑ 3.15 WHODAS Then ❑ 3.16 Next steps **Important:** For all children younger than 7 the PEDI-CAT is to be completed by an early childhood partner in addition to any other severity information provided by the nominee or child representative (for example DSM-5). For children who are aged 7 or 8, the PEDI-CAT may also be completed if the results of a more appropriate severity tool are not available.

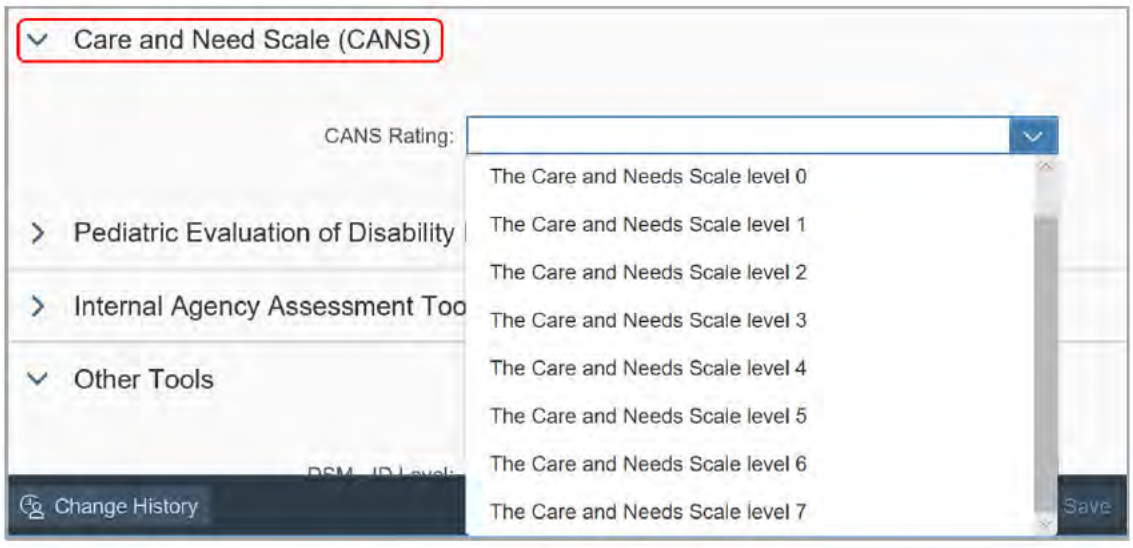
3. Procedure

3.1 Acquired Brain Injury

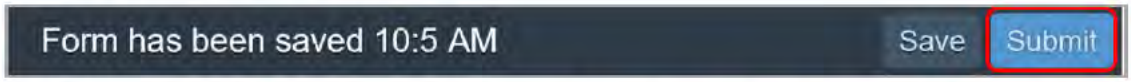
1. Use this table to decide which severity tool to use when the participant has a primary disability of acquired brain injury.

Age	Preference	Severity tool by order of preference	Source of assessment
0-16	1st	PEDI-CAT	Internal
17+	1st	Care and Needs Scale (CANS)	Medical professional (or equivalent)
17+	2nd	WHODAS	Internal

2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. Select the rating from **CANS Rating** list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.



7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.2 Autism

1. Use this table to decide which severity tool to use when the participant has a primary disability of autism.

Age	Preference	Severity tool by order of preference	Source of assessment
All	1st	Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5)*	Medical professional (or equivalent)
All	2nd	Vineland Adaptive Behaviour Scale, Third Edition (Vineland-3)	Medical professional (or equivalent)
All	3rd	Vineland Adaptive Behaviour Scale, Second Edition (Vineland-II)	Medical professional (or equivalent)
0-16	4th	PEDI-CAT	Internal
17+	4th	WHODAS	Internal

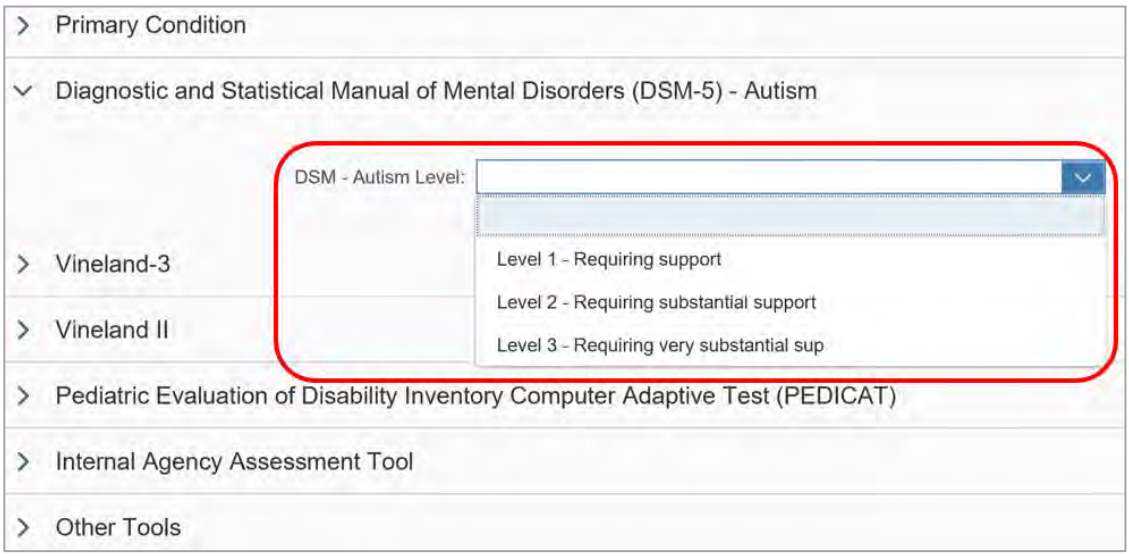
Note: There are different DSM-5 levels for intellectual disability (ID) and autism.

Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

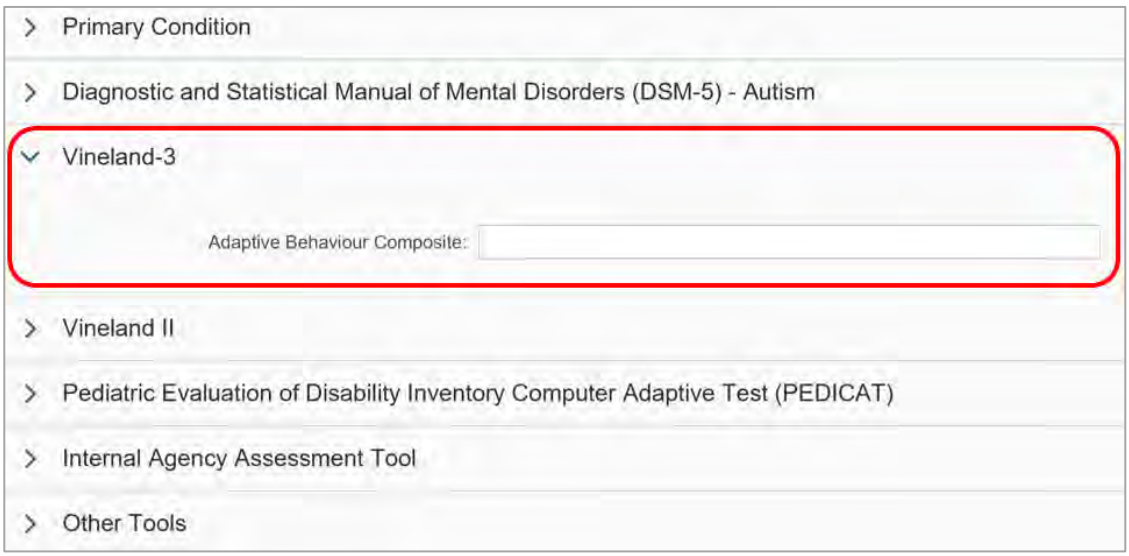
2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.

5. The **Create – Severity Scales Tools** form opens. You will update different parts of the form based on the assessment information you have:

   - **DSM-5**: Select the level from the **DSM – Autism Level** list. For information on what level to choose to go to 3.2.1 What is the DSM-5 Autism.

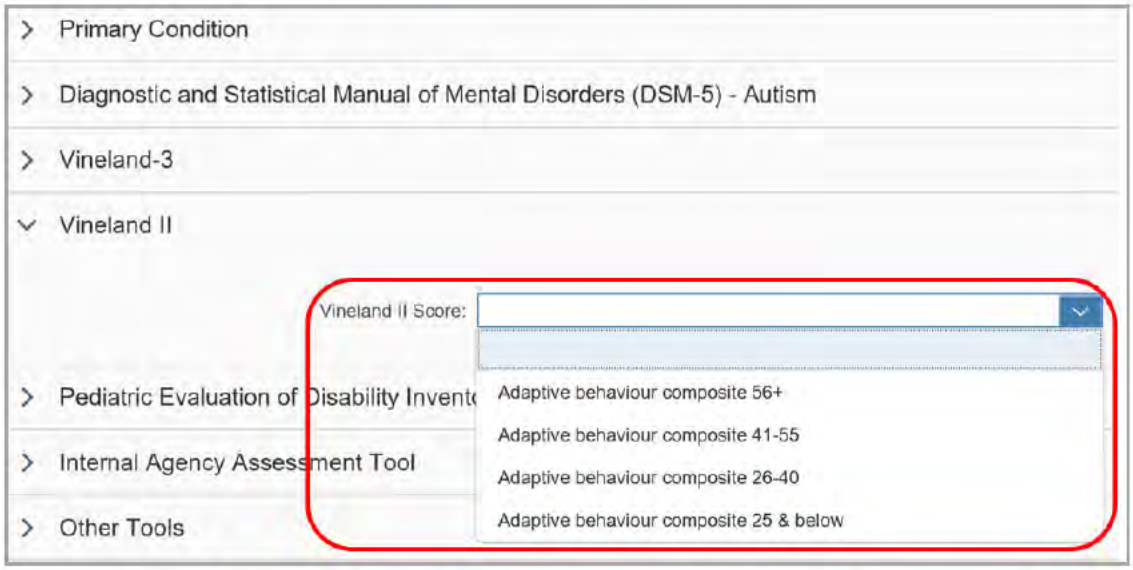


   - **Vineland-3**: enter the adaptive behaviour composite score in the **Adaptive Behaviour Composite** field. For information on the Vineland-3 go to 3.2.2 What is the Vineland-3.

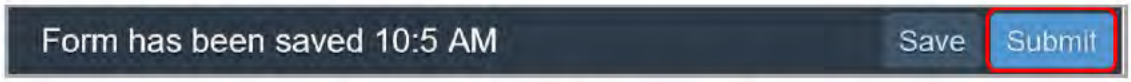


Note: Enter the score as a whole number, with no decimal places.

- **Vineland-II**: Select the level from the **Vineland II Score** list. For information on what level to choose to go to 3.2.3 What is the Vineland-II.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.



7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.2.1 DSM-5 Autism

The severity of autism is determined using measures of social communication and of restrictive, repetitive behaviours.

Where a participant presents with DSM-5 Autism assessment information, the following guidance should be followed to record this information in the System:

Rating	Description
Level 1	Requiring Support
Level 2	Requiring substantial support
Level 3	Requiring very substantial support

3.2.2 Vineland-3

The Vineland Adaptive Behaviour Scale, Third Edition (Vineland-3) is a revised version of the Vineland Adaptive Behaviour Scale, Second Edition (Vineland-II) providing an overall adaptive behaviour composite.

It assesses three domains: Communication, Daily Living Skills, and Socialization.

Vineland-3 also offers optional Motor Skills and Maladaptive Behaviour domains for situations where these areas are of concern.

3.2.3 Vineland-II

The Vineland Adaptive Behaviour Scale, Second Edition (Vineland-II) assesses the personal and social skills needed for everyday living.

It assesses many domains and provides an overall adaptive behaviour composite. The core domains within the Vineland-II are Communication, Daily Living Skills, Socialisation and Motor Skills.

Use the Vineland-II assessment information the participant provides you with and the table below to determine the Adaptive behaviour composite score for the System:

Category	Number	Description
Mild	01	Adaptive behaviour composite 56+
Moderate	02	Adaptive behaviour composite 41 - 55
Severe	03	Adaptive behaviour composite 26 - 40
Profound	04	Adaptive behaviour composite 25 and below

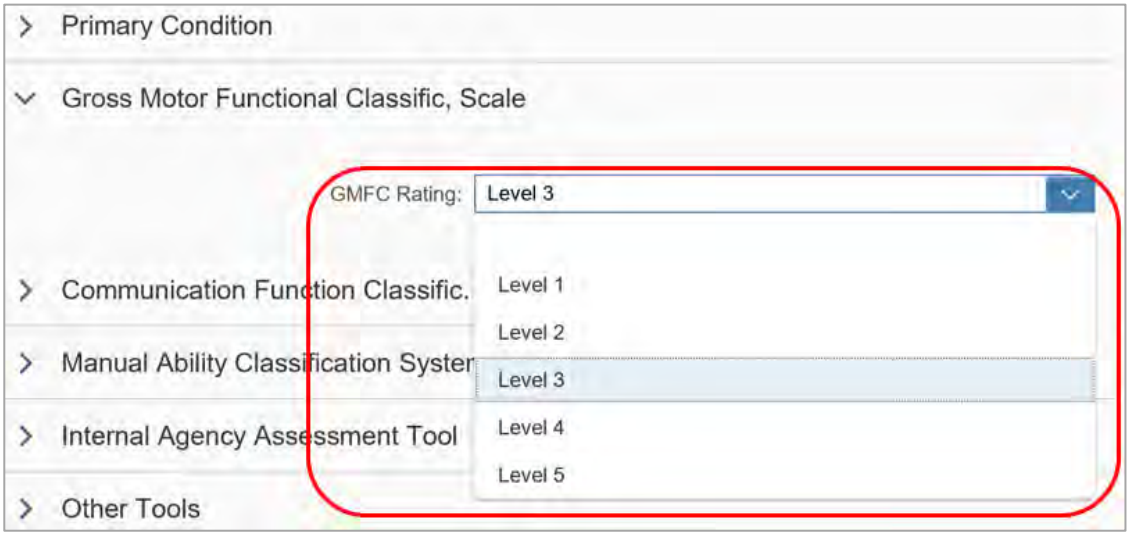
3.3 Cerebral Palsy

1. Use this table to decide which severity tool to use when the participant has a primary disability of cerebral palsy.

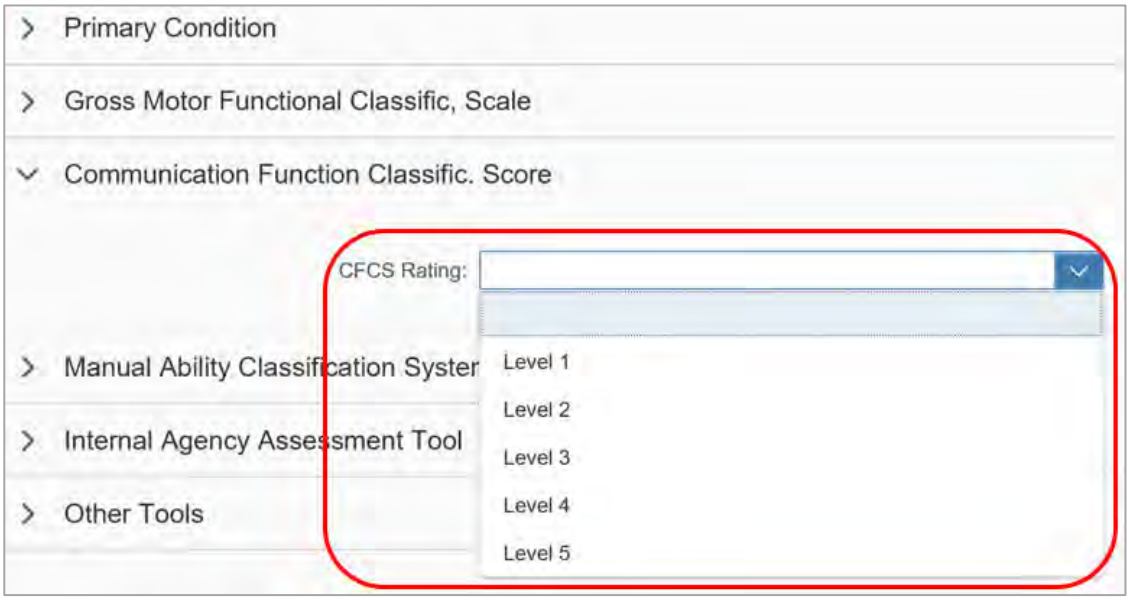
Age	Preference	Severity tool by order of preference	Source of assessment
All	1st	Cerebral Palsy Gross Motor Functional Classification Scale (GMFCS)	Medical professional (or equivalent) OR Internal
All	2nd	Cerebral Palsy: Communication Function Classification System (CFCS)	Medical professional (or equivalent)
All	3rd	Cerebral Palsy: Manual Ability Classification Scale (MACS)	Medical professional (or equivalent)

Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

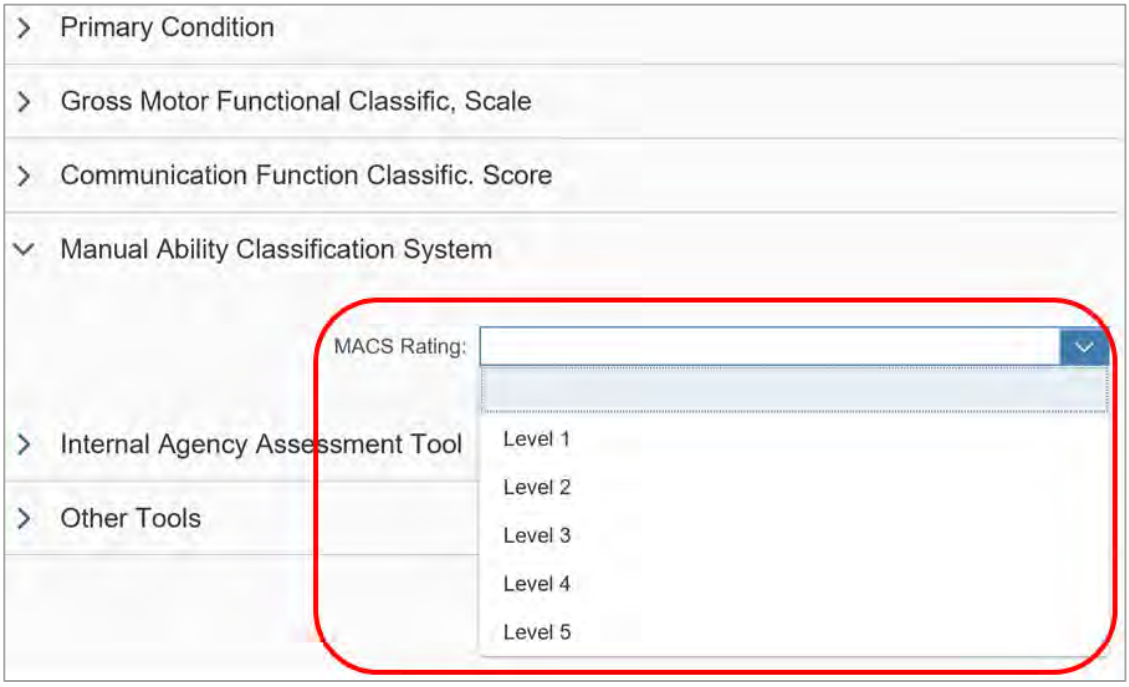
2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. You will update different parts of the form based on the assessment information you have:
   - **GMFCS**: Select the level from the **GMFC Rating** list.



- **CFCS**: Select the level from the **CFCS Rating** list



- **MACS**: Select the level from the **MACS Rating** list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.

7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.4 Developmental Delay (0-6 only)

Developmental delay is a term used to describe how a child is presenting in relation to their developmental milestones. A child who is considered to have a developmental delay is taking longer to reach, or has not reached, age-appropriate developmental milestones.

When the participant has a primary disability of developmental delay you must use the PEDI-CAT tool.

Important: Developmental delay is different to Global Developmental Delay (GDD).

If the participant has a primary disability of GDD follow the procedure in 3.5 Intellectual Disability, Global Developmental Delay or Down Syndrome.

For information about GDD go to Disability Snapshot – Global Developmental Delay.

3.5 Intellectual Disability, Global Developmental Delay or Down Syndrome

1. Use this table to decide which severity tool to use when the participant has a primary disability of:
   - intellectual disability
   - global developmental delay
   - down syndrome.

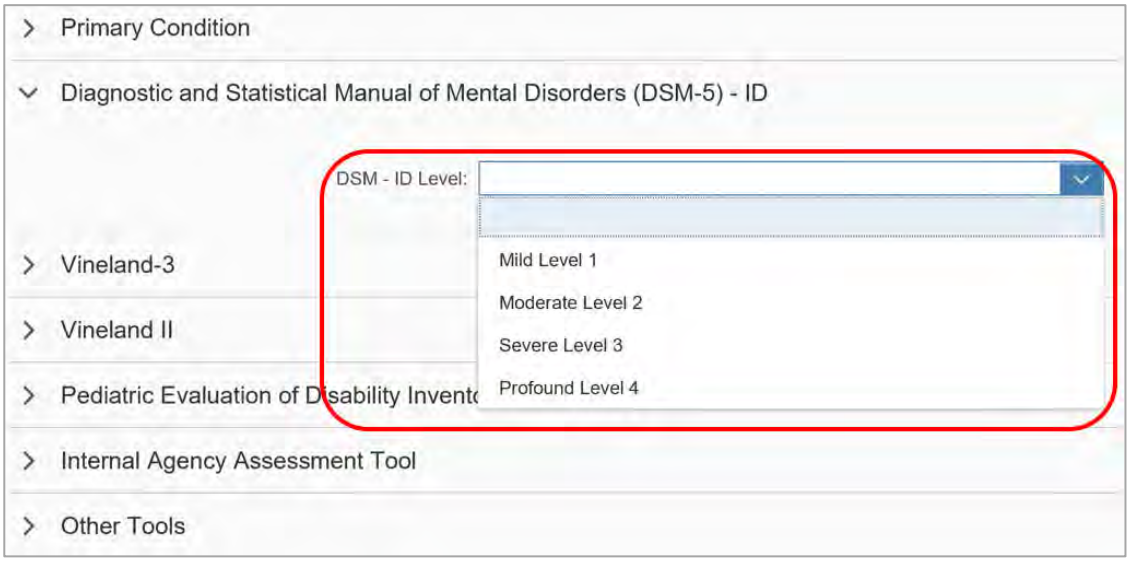
Age	Preference	Severity tool by order of preference	Source of assessment
All	1st	Diagnostic and Statistical Manual of Mental Health Disorders, Fifth Edition (DSM-5)*	Medical professional (or equivalent)
All	2nd	Vineland Adaptive Behaviour Scale, Third Edition (Vineland-3)	Medical professional (or equivalent)
All	3rd	Vineland Adaptive Behaviour Scale, Second Edition (Vineland-II)	Medical professional (or equivalent)
0-16	4th	PEDI-CAT	Internal
17+	4th	WHODAS	Internal

Note: There are different DSM-5 levels for Intellectual Disability (ID) and Autism.

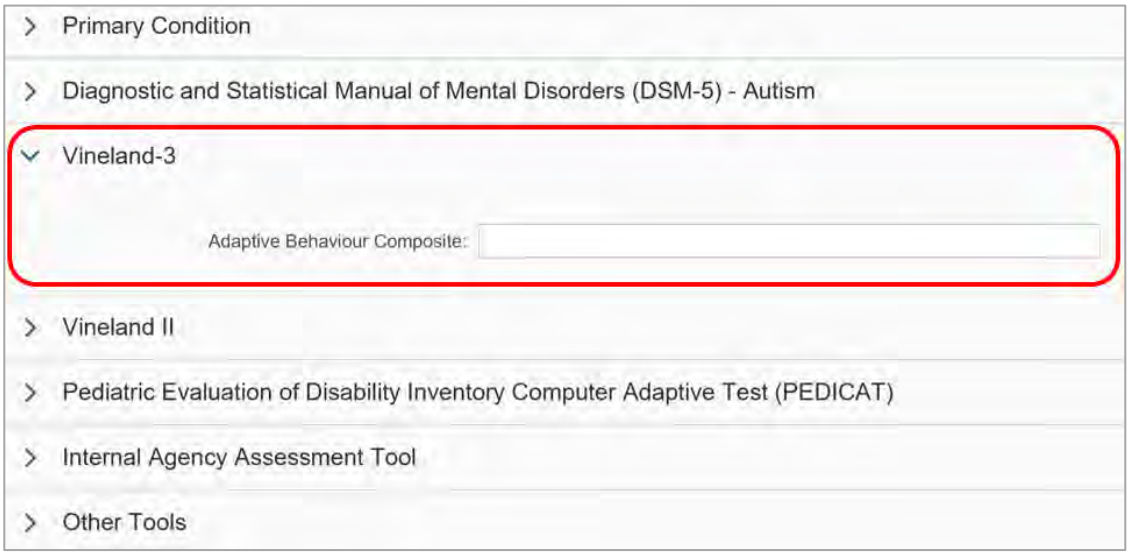
Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. You will update different parts of the form based on the assessment information you have:

- **DSM-5**: Select the level from the **DSM – ID Level** list. For information on what level to choose to go to 3.5.1 What is the DSM-5 Intellectual Disability (ID).

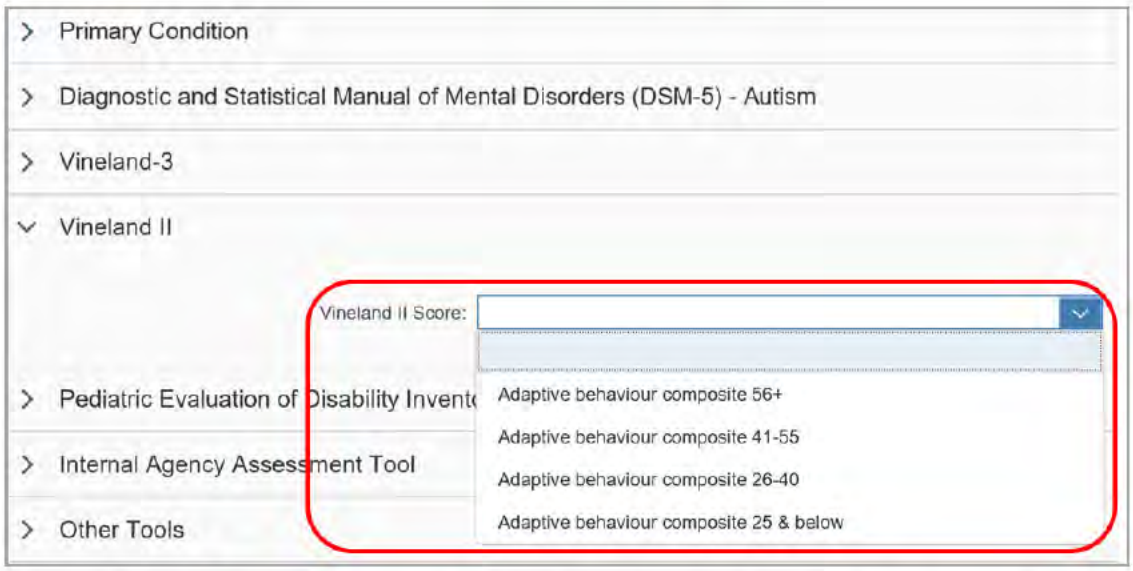


- **Vineland-3**: enter the adaptive behaviour composite score in the **Adaptive Behaviour Composite** field. For information on the Vineland-3 go to 3.5.2 What is the Vineland-3.

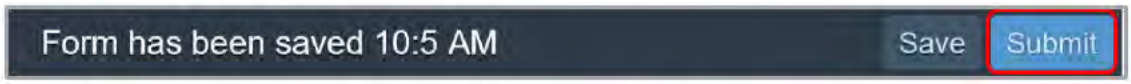


Note: Enter the score as a whole number, with no decimal places.

- **Vineland-II**: Select the level from the **Vineland II Score** list. For information on what level to choose to go to 3.5.3 What is the Vineland-II.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.



7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.5.1 DSM-5 Intellectual Disability (ID)

The DSM-5 ID uses the measure of cognitive function (IQ) and a measure of adaptive functioning to rate an individual in a four-level scale.

Where a participant presents with DSM-5 ID assessment information, the following guidance should be followed to record this information in the System:

Rating	Description
Level 1	Mild
Level 2	Moderate
Level 3	Severe
Level 4	Profound

3.5.2 Vineland-3

The Vineland Adaptive Behaviour Scale, Third Edition (Vineland-3) is a revised version of the Vineland Adaptive Behaviour Scale, Second Edition (Vineland-II) providing an overall adaptive behaviour composite.

It assesses three domains: Communication, Daily Living Skills, and Socialization.

Vineland-3 also offers optional Motor Skills and Maladaptive Behaviour domains for situations where these areas are of concern.

3.5.3 Vineland-II

The Vineland Adaptive Behaviour Scale, Second Edition (Vineland-II) assesses the personal and social skills needed for everyday living.

It assesses many domains and provides an overall adaptive behaviour composite. The core domains within the Vineland-II are Communication, Daily Living Skills, Socialisation and Motor Skills.

Use the Vineland-II assessment information the participant provides you with and the table below to determine the Adaptive behaviour composite score for the System:

Category	Number	Description
Mild	01	Adaptive behaviour composite 56+
Moderate	02	Adaptive behaviour composite 41 - 55
Severe	03	Adaptive behaviour composite 26 - 40
Profound	04	Adaptive behaviour composite 25 and below

3.6 Internal Agency Assessment Tool

The **Internal Agency Assessment Tool** is in the **Update Severity Tools** screen. You should:

- not use this tool.
- ignore any default score generated
- not remove or change the internal rating level, as this may cause an error in the System.

When the **Internal Agency Assessment Tool** is the only tool available within the **Update Severity Tools** task:

- update the **Primary Disability** in the System using Standard Operating Procedure - Change Disability (Post Access)
- the preferred severity tool is now available in the **Update Severity Tools** task.

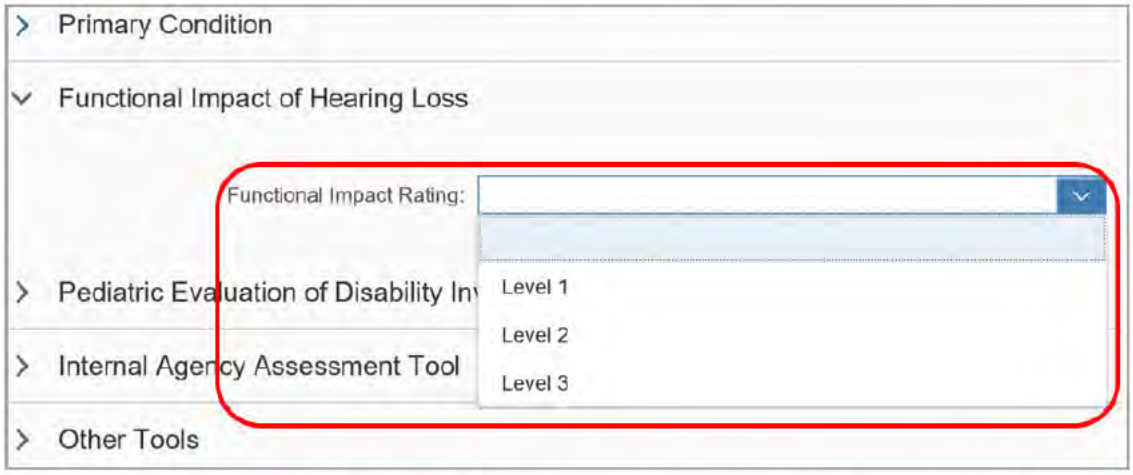
3.7 Hearing

1. Use this table to decide which severity tool to use when the participant has a primary disability of hearing.

Age	Preference	Severity tool by order of preference	Source of assessment
17+	1st	Hearing Severity Tool: Functional Impact of Hearing Loss Assessment Tool	Internal
7-16	1st	PEDI-CAT If you are unable to complete PEDI-CAT for age 7-16, complete the modified Hearing Severity Tool: Functional Impact of Hearing Loss Assessment Tool. You may also use this Tool in addition to the PEDI-CAT.	Internal
Younger than 7	1st	PEDI-CAT	Internal

Important: Hearing acuity assessment report will not impact the funding generated for the participant.

2. Complete the Hearing Severity Tool or follow guidance in 3.14 PEDI-CAT.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. Select the level from **Functional Impact of Hearing Loss** list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.

7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.8 Multiple Sclerosis

1. Use this table to decide which severity tool to use when the participant has a primary disability of Multiple Sclerosis.

Age	Preference	Severity tool by order of preference	Source of assessment
All	1st	Disease Steps	Medical professional (or equivalent)
All	2nd	Multiple Sclerosis Severity Tool: Patient Determined Disease Steps (PDDS)	Medical professional (or equivalent) OR Internal
All	3rd	Expanded Disability Status Scale (EDSS)	Medical professional (or equivalent)

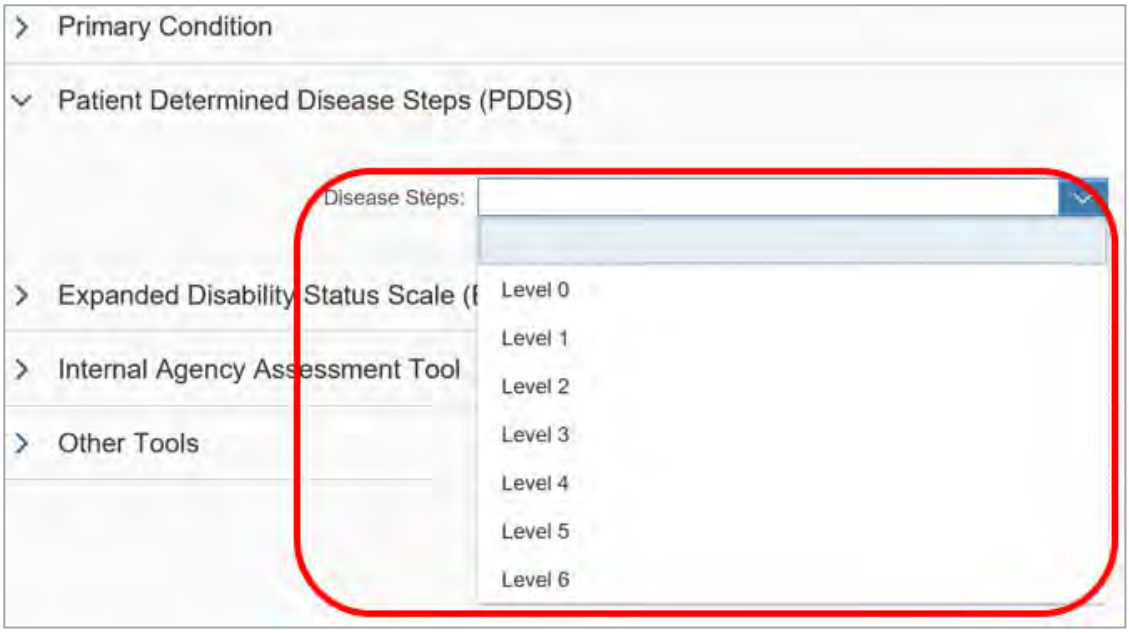
Note: the PDDS level needs to be converted to a Disease Steps level to enter it into the System. Refer to Multiple Sclerosis Severity Tool: Patient Determined Disease Steps (PDDS).

Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

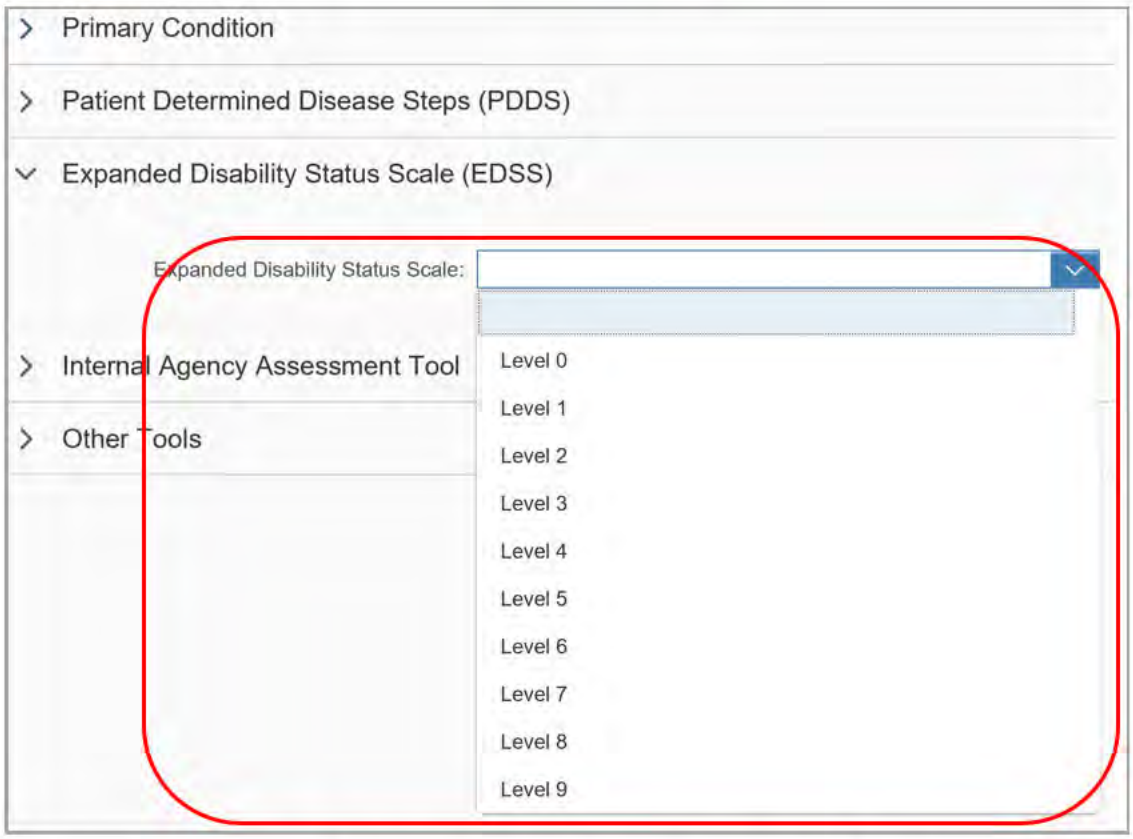
2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. You will update different parts of the form based on the assessment information you have:

   Note: You do not have to complete both the Disease Steps and the Patient Determined Disease Steps. Either one will generate funding for the participant.

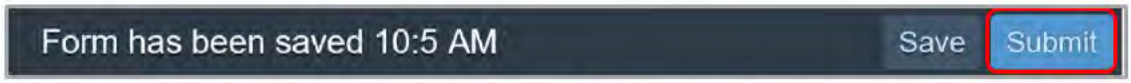
   - **PDDS:** Select the level from the Disease Steps list.



   - **EDDS**: Select the level from the Expanded Disability Status Scale list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.



7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.9 Psychosocial disability

1. Use this table to decide which severity tool to use when the participant has a primary disability of psychosocial disability.

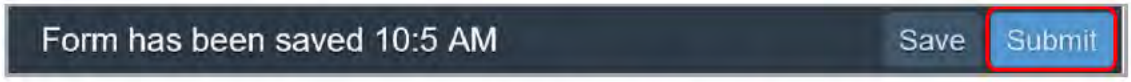
Age	Preference	Severity tool by order of preference	Source of assessment
17+	1st	Life Skills Profile (LSP-16)	Medical professional (or equivalent)
0-16	1st	PEDI-CAT	Internal

Age	Preference	Severity tool by order of preference	Source of assessment
17+	2nd	WHODAS	Internal

Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. Enter the score in the the **Life Skills Profile (LSP-16)** box. For information on what level to choose go to 3.9.1 What is the Life Skills Provile 16 (LSP-16).

6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.



7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.9.1 Life Skills Profile-16 (LSP-16)

The Life Skills Profile-16 (LSP-16) assesses areas such as social relationships and a person's ability to carry out day-to-day tasks.

The four subscales in the LSP-16 are withdrawal, self-care, compliance and anti-social behaviour.

The total score can range from 0 to 48, ascending with the severity of the impact of the disability.

The LSP-16 score corresponds to a LSP-16 level. The LSP-16 level will affect the amount of funding generated for the participant.

LSP-16 score	LSP-16 Level
Less than 10	Level 1
10 – 22	Level 2
23 – 29	Level 3
30 or above	Level 4

3.10 Spinal Cord Injury

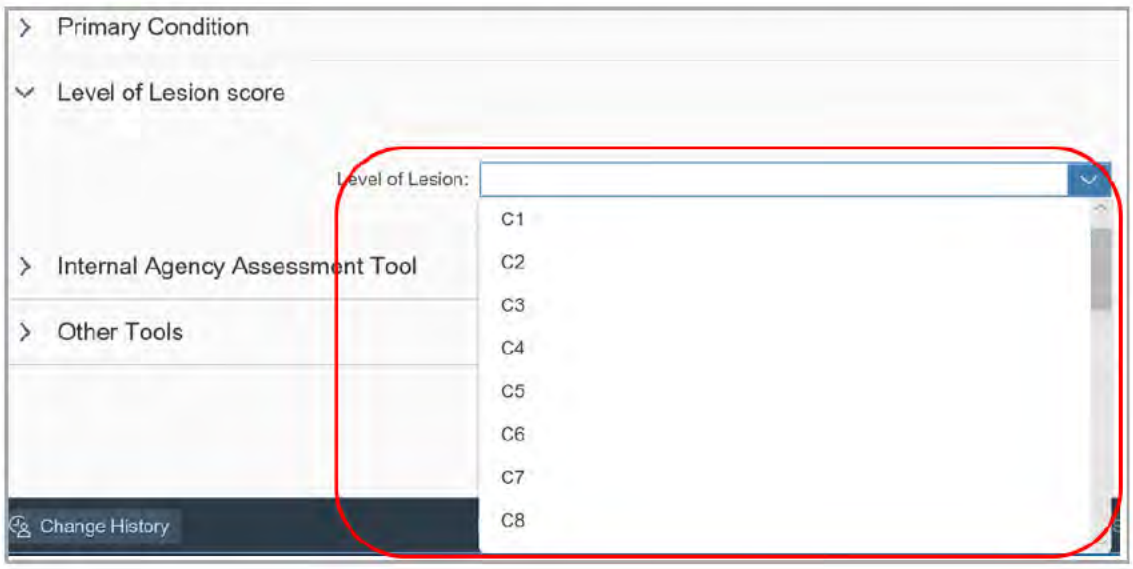
1. Use this table to decide which severity tool to use when the participant has a primary disability of spinal cord injury.

Age	Preference	Severity tool by order of preference	Source of assessment
All	1st	Level of Lesion (where on the spine the injury has occurred)	Medical professional (or equivalent)
0-16	2nd	PEDI-CAT	Internal
17+	2nd	WHODAS	Internal

Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.

4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. Select the level from the **Level of Lesion** list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.

7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.10.1 American Spinal Injury Impairment Scale (ASIA)

American Spinal Injury Impairment Scale (ASIA) measures the completeness of the injury.

For the participant with a spinal cord injury as a primary disability it is important that you specify the level of spinal cord injury completeness (for example complete vs. incomplete). This will affect the amount of funding generated for the participant.

If the participant has an ASIA grade use the table below to determine if the spinal cord injury is complete or incomplete.

ASIA Grade	Result
A	Complete
B, C D, E	Incomplete

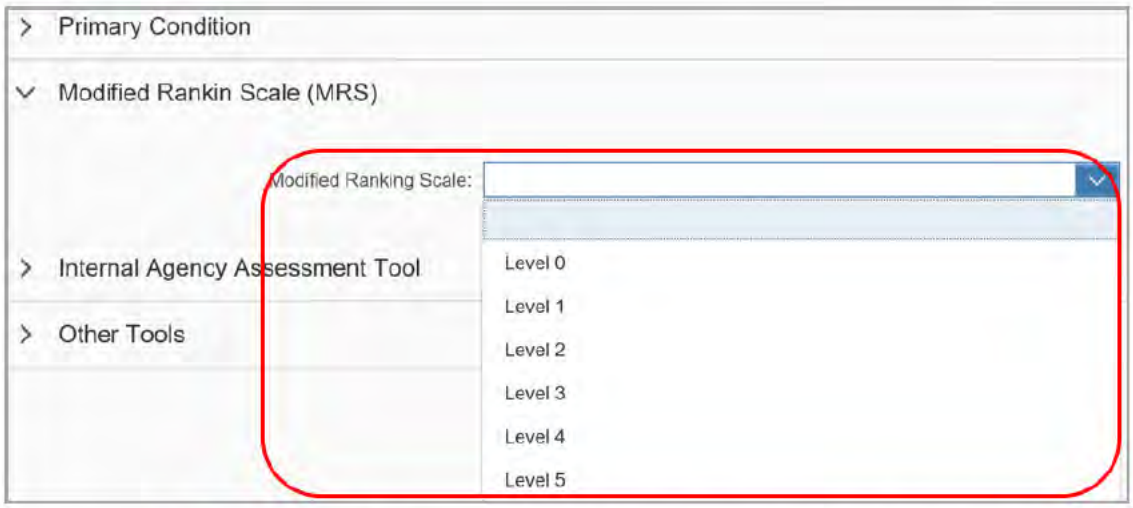
3.11 Stroke

1. Use this table to decide which severity tool to use when the participant has a primary disability of stroke.

Age	Preference	Severity tool by order of preference	Source of assessment
All	1st	Modified Rankin Scale (mRS)	Medical professional (or equivalent)
All	2nd	Stroke Severity Tool: Modified Rankin Scale	Internal

Note: Complete the PEDI-CAT in addition to the above for all children younger than 7.

2. Ask the participant if they have the required assessment report. If:
   - **Yes** go to step 3
   - **No** complete the preferred internal assessment tool, in the table above.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. Select the level from the **Modified Rankin Scale** list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.

7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

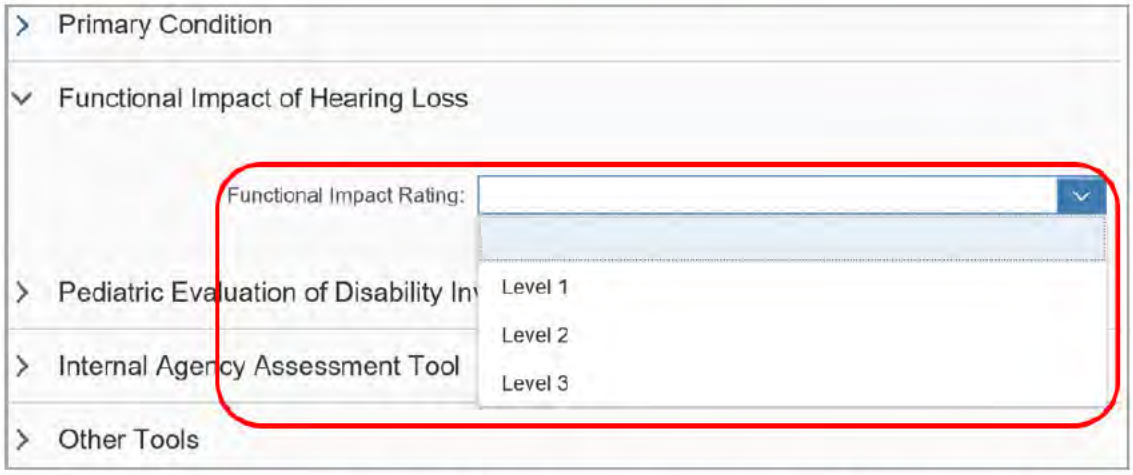
3.12 Vision

1. Use this table to decide which severity tool to use when the participant has a primary disability of a vision impairment.

Age	Preference	Severity tool by order of preference	Source of assessment
17+	1st	Vision Severity Tool: Functional Impact of Vision Loss Assessment Tool	Internal
7-16	1st	PEDI-CAT If you are unable to complete PEDI-CAT for age 6-17 complete the modified Vision Severity Tool: functional Impact of Vision Loss Assessment Tool.	Internal
Younger than 7	1st	PEDI-CAT	Internal

Important: A participant may provide a vision acuity assessment report. This report will **not** impact the funding generated for the participant. You will need to use one of the severity tools referenced in the Vision table above.

2. Complete the Vision Severity Tool or follow guidance in 3.14 PEDI-CAT.
3. Attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
4. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
5. The **Create – Severity Scales Tools** form opens. Select the level from **Functional Impact of Vision Loss** list.



6. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.

7. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.13 Other Primary Disability

1. Use this table to decide which severity tool to use when the participant's primary disability is recorded in the System as **Other primary disability**.

Age	Preference	Severity tool by order of preference	Source of assessment
0-16	1st	PEDI-CAT	Internal
17+	1st	WHODAS	Internal

If:

- **PEDI-CAT** go to 3.14 PEDICAT
- **WHODAS** go to 3.15 WHODAS.

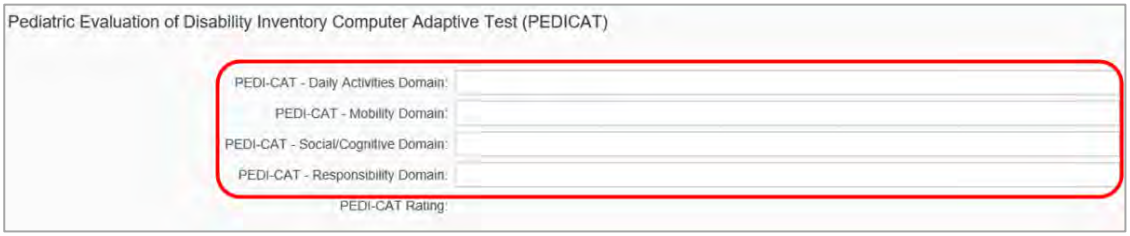
3.14 PEDI-CAT

Completing the PEDI-CAT will support the measurement of severity change over time for consistent reporting. For more information on the PEDI-CAT go to 3.14.1What is the PEDI-CAT.

1. . You can complete the PEDI-CAT if you are an:
   - early childhood partner
   - local area coordinator
   - NDIS planner
   - NDIS plan delegate.

   Note: For children younger than 7 the PEDI-CAT is administered by the early childhood partner only. For children aged 7 and 8 the PEDI-CAT may be administered by an early childhood partner, a local area coordinator or an NDIS planner.
2. Check that the participant needs the PEDI-CAT assessment tool. Children aged:
   - **Younger than 7:** must have the PEDI-CAT score in addition to any other assessment tool.
   - **7-16**: only need the PEDI-CAT if a more appropriate tool cannot be recorded.
3. Conduct the PEDI-CAT assessment with the participant and/or their nominee.

   Note: The Responsibility domain should only be completed for children aged 3 years and over.
4. Generate the PEDI-CAT Detailed Assessment Report.
5. Note each of the four T-scores. These will need to be entered into the System.
6. Attach a copy of the PEDI-CAT Detailed Assessment Report to the System using Standard Operating Procedure – Manage inbound documents.
7. In **Pre-Planning – Staff Tasks** select **Update Severity Tools**.
8. The **Create – Severity Scales Tools** form opens. Enter the T-score results from the PEDI-CAT Detailed Assessment Report to the Domain Areas in the System:
   - When the T-score is generated and displayed as **<10** (less than 10), record the score as 1 in the System.
   - When the T-score generated is **greater than or equal to 10** record the exact score in the System.
   - For children under 3 years the **PEDI-CAT - Responsibility Domain** should be greyed. You should not be able to edit this field. The Responsibility domain should only be completed for children aged 3 years and over.



9. You can select **Save** at any time to save the form and return to complete it later. When you are finished select **Submit**.

10. A confirmation message appears. Select **Close**. The **Pre-Planning** page displays and **Update Severity Tools** has a green tick to show it is complete.

3.14.1 What is the PEDI-CAT

The PEDI-CAT contains questions asked under four domains:

- Daily Activities
- Mobility
- Social/Cognitive
- Responsibility

The PEDI-CAT:

- is an application outside of the NDIS Business System.
- will produce a PEDI-CAT Detailed Assessment Report with:
  - scaled scores (i.e. raw scores)
- normative scores (T-scores and age-percentile scores).

For more information go to PEDICAT page (internal). It has information on how to:

- check if you have PEDI-CAT installed
- request access to PEDI-CAT
- download PEDI-CAT
- activate PEDI-CAT.

3.15 WHODAS

The WHODAS is the only severity tool that is recorded outside of the **Update Severity Tools** task. It has its own task in the System under the **Pre-Planning** tab.

1. Determine that you need to complete the WHODAS assessment tool. This means there is no other severity assessment on the participant's record.

   Note: You can complete the WHODAS in addition to a disability-specific tool. This should not change the funding generated.

2. Complete the WHODAS with the participant using Standard Operating Procedure – Complete the WHODAS.

3.16 Next Steps

1. When the participant's severity level has changed clearly justify the change to assessment level or score. Then attach a copy of the assessment report to the System using Standard Operating Procedure – Manage inbound documents.
2. Continue with pre-planning using guidance on the Service Guidance Pre-Planning intranet page.

4. Appendices

4.1 Appendix 1: Tools for assessing the participant's functional capacity

Severity Tool information comes from three sources. In order of preference these are:

- Disability specific assessments
- Internal disability specific Severity Tools
- Assessments not specific to a disability type.

4.1.1 Disability specific assessments:

- are completed by the participant's treating health professional. Information on disability specific assessment reports in on the Providing evidence of your disability page on the NDIS website
- cannot be completed by National Disability Insurance Agency (NDIA) staff and partners
- examples are the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5) for Intellectual Disability and Autism.

4.1.2 Internal disability specific Severity Tools:

- can be completed by Agency staff and partners.
- are:
  - Gross Motor Function Classification Scale (GMFCS) for Cerebral Palsy
  - Modified Rankin Scale (mRS) for Stroke
  - Disease Steps for Multiple Sclerosis
  - Hearing tool
  - Vision tool

4.1.3 Assessments not specific to a disability type:

- Can be completed by NDIA staff.
- Assessments not specific to a disability type are:
  - PEDI-CAT
  - World Health Organisation Disability Assessment Schedule (WHODAS) 2.0.

4.2 Appendix 2: Collecting functional capacity assessment score or level

The participant's functional capacity assessment score or level can be collected by:

- the National Access and Workload Management branch (NAWM) when assessing the participant's eligibility to the National Disability Insurance Scheme (NDIS).
- a delegate when NAWM was unable to collect the severity level or score, or where there has been a change in level of severity.

When collecting functional capacity assessment information, the score of an **external assessment** needs to be provided by:

- the participant
- their nominee
- their child representative
- their treating health professional.

You must record the severity assessment score against the primary disability. When the participant has more than one disability listed, the primary disability is the impairment which has the greatest impact. For information on updating the participant's disability go to Standard Operating Procedure – Change Disability (Post Access).

4.3 Appendix 3: Providing evidence of severity of disability

The plan developer must sight a copy of the assessment report before the result, or score is entered into the System.

If a preferred assessment tool is not available, evidence of the impact of the disability must be sighted. This can be supplied in the form of a signed letter or a letter on a formal letterhead from the participant's treating health professional. Evidence of the severity of the disability should include:

- type of disability
- date disability diagnosed
- how long the disability will last
- available treatments
- how the disability impacts the participant's everyday life. For example, mobility/motor skills, communication, social interaction, learning, self-care, self-management.

The letter needs to be written and signed the participants treating health professional.

Once the preferred evidence of impact of the disability is received, add the result to the System. Information on how to do this is in the Standard Operating Procedure – Manage inbound documents.

4.3.1 Other reports

The following reports may be supplied to support a participant's level of severity, however they will not impact the funding generated in the participant's plan:

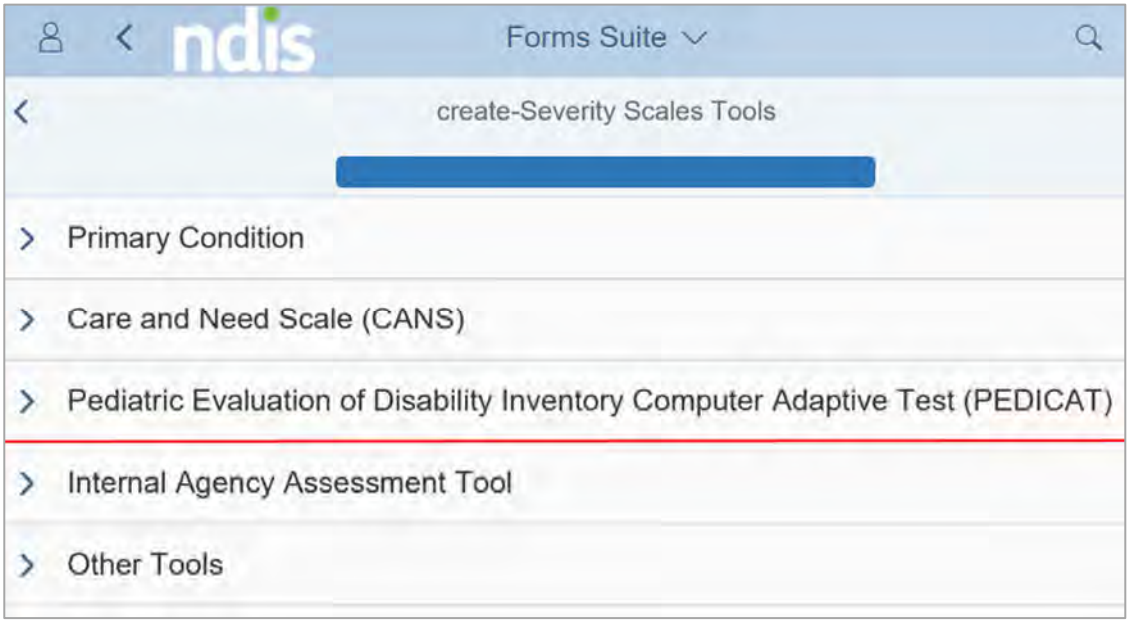
- Hearing: Hearing Acuity information.
- Vision: Vision Acuity information.
- Health of the Nation Survey (HoNOS).

You must upload a copy of any reports received as an inbound document. Information on how to do this is in the Standard Operating Procedure – Manage inbound documents.

4.4 Appendix 5: Overview of the create-Severity Scales Tools form

You will enter the result or score from an assessment in the **Update Severity Tools** task. This is used to generate the TSP in the participant's plan. You need to apply reasonable and necessary decision making to any funding generated. Funding in the participant's plan must be individualised for each participant's disability support needs.

- Severity tools that impact the funding generated will appear above the **Internal Agency Assessment Tool** field.
- Report results that do not impact the funding generated will appear under the **Agency Assessment Tool**.



Note: The fields that show in this form will change depending on the **Primary Disability** assigned to the participant.

5. Related procedures or resources

- Our Guideline – Creating Your Plan
- Standard Operating Procedure – Change Disability (Post Access)
- Standard Operating Procedure – Manage inbound documents
- Standard Operating Procedure – Complete the WHODAS
- Standard Operating Procedure – Prepare and complete the planning conversation

6. Feedback

If you have any feedback about this Standard Operating Procedure, please complete our Feedback Form.

7. Version control

Version	Amended by	Brief Description of Change	Status	Date
1.0	CW0032	Class 2 approved. Standard Operating Procedure moved to the new SOP format to be used with the Creating your plan Operational Guidelines. Update to the American Spinal Injury Impairment Scale (ASIA) table. Additional information added on calculating the LSP-16 score.	APPROVED	2021-02-17
2.0	JS0082	Class 1 approved. Minor update of wording	APPROVED	2022-04-27
3.0	CW0032 IIW664	Class 2 approved. Updated to align with the early childhood age range change. Updates to support early childhood partners to plan for children aged 7 or 8.	APPROVED	2023-06-21

Practice Guide – Identifying Housing Solutions

Contents

1. Purpose

The purpose of this Practice Guide is to provide guidance to staff and Partners in the Community (Partners) when considering the inclusion of home and living supports in the participant's plan.

2. To be used by

- Plan Developers – Planners and Partners in the Community (Early Childhood Partners and Local Area Co-ordinators [LACs])
- NDIA Plan Delegates
- Integrated Housing Team

3. Scope

Participants are encouraged to complete a Home and Living Supports Request Form (external). This is reviewed along with other supporting documentation from the participant and/or their allied health professional. The information supports plan developers, Housing Assessors or the Housing Panel to identify the appropriate home and living response for the participant to pursue their goals.

The NDIA will use the documentation to assist with determining whether a participant's home and living support needs are reasonable and necessary.

When deciding to include any support in a participant's plan, the NDIA must consider items in the *National Disability Insurance Scheme Act 2013* (NDIS Act), including the participant's statement of goals and aspirations. The NDIA must be satisfied that each support meets each of the reasonable and necessary criteria outlined in:

- section 34(1)(a)-(f) of the NDIS Act, and
- Part 5 of the *National Disability Insurance Scheme (Supports for Participants) Rules 2013*.

For further information refer to Our Guideline – Creating your Plan.

There are different types of home and living solutions and support needs which may be considered to best meet the participant's individual circumstances and lifestyle.

Housing solutions may include:

- social housing (public and community housing)
- home ownership
- shared equity

- private rental
- Specialist Disability Accommodation (SDA).

Support needs may include:

- Capacity building
- Assistive Technology (AT)
- Home modifications
- Short or medium term accommodation
- Individualised Living Options (ILO)
- Supported Independent Living (SIL)

The participant may be supported to identify, coordinate and ensure the required supporting documentation is completed and provided to the NDIA when requested, for reasonable and necessary decision making, by the following people:

- Participant and/or their informal support network
- LAC
- Support Coordinator.

3.1 Current position of the NDIA

The following provisions of funding for home and living support(s) need to be taken into account:

- All types of suitable and comparable home and living solutions and support needs have been considered and justification has been provided as to their suitability or unsuitability.
- The identified home and living solution and/or supports will assist to facilitate the participant's independence, social and economic participation.
- The home and living supports are sustainable for the participant and/or their informal support network.
- Risks/impacts to the participant's current and proposed living arrangement, informal care support, level of independence, social and economic participation have been identified.

- The participant's immediate and longer term home and living support needs have been considered, including opportunities for capacity building and skill development.
- Supports do not relate to day-to-day living expenses.
- When a participant resides in SDA, funding for home modifications will not be included in their plan. The provider of SDA is funded, according to the enrolled dwelling type, to meet the individual needs of each resident.

4. Types of housing

There are different types of housing solutions that must be considered when identifying a participant's suitable home and living solution.

4.1 Public housing

Public housing is generally a long-term housing solution for people on low incomes who are most in need. Public housing is managed by state and territory governments and there are usually significant waiting periods for this type of accommodation. Applications for public housing are submitted through local state government offices. Rental contribution is approximately 25% of the household income.

4.2 Community housing

Community housing offers secure long-term, affordable housing options to individuals who may be disadvantaged in the private rental market. It is managed by not-for-profit organisations, known as community housing organisations. Examples of community housing are The Salvation Army Australia or Community Housing Ltd.

Generally, tenants pay similar rent to public housing tenants, which is equivalent to approximately 25% of the household's assessable income, or the market rent for the property (whichever is lower). In some community housing settings, there may be group share options, where tenants can have their own bedroom but share facilities such as the bathroom, kitchen and laundry areas.

4.3 Home ownership

Home ownership applies to participants currently living in their own/family owned home or looking to purchase their own home. The NDIA may consider funding for home modifications, AT, capacity building supports and/or SIL supports which are deemed reasonable and necessary to enable the participant to live in their own home.

4.4 Shared equity

A barrier to home ownership is the inability to save a deposit for a home loan on a low-medium wage or income payment. Shared equity can best be described as a 'shared home-ownership financial model'. This is where the cost of the dwelling purchase price is contributed through a range of partnerships (for example, families/participants purchasing together, developers, land and homeowners and cooperatives) in conjunction with the participant. As with a home loan, there are eligibility requirements and criteria that need to be considered.

Most state, territory and local governments are currently supporting various housing initiative(s) that assist singles, couples or families with the costs associated with becoming a home owner, or when considering the purchase of a home with other investors.

4.5 Private rental market

The private rental market may include opportunities listed in the newspaper, online, through real-estate agents and websites. This may include sharing a home with others to reduce costs. Rent and utilities are paid by the participant at the market rate.

4.6 Specialist Disability Accommodation

SDA is specialised housing designed to support people with extreme functional impairment or very high support needs. It is not a solution designed to deal with homelessness or other similar matters. SDA does not refer to the support services but the homes in which these are delivered. SDA may include specialist designs for people with very high needs or may have a location or features that make it suitable for providing complex supports for independent living.

The three different types of SDA are:

- new
- in-kind
- existing.

Participants that can be suitable for SDA are those with:

- very high mobility needs
- intellectual or cognitive disability who have very high person-to-person support needs.

The two occasions when SDA may be included in a plan are:

- when there is a new SDA decision
- when the participant was already residing in disability related supported accommodation at the time of transition to the NDIS.

For further information about SDA, and which participants are eligible for SDA, refer to Appendix C – Specialist Disability Accommodation.

5. Types of support

There are different types of supports which must be considered when identifying a participant's suitable home and living solution(s) and support needs.

5.1 Capacity building – skill development

Capacity building supports enable a person to increase their ability to manage their day-to-day activities independently and can be beneficial to support participants in their transition to an alternate home and living solution. These supports are designed to deliver an improved measurable outcome for the participant while reducing the need for funded supports in the future.

Refer to Appendix D – Types of support Capacity Building - Skill Development.

5.2 Assistive Technology

AT is defined by the World Health Organisation as 'any device or system that allows individuals to perform tasks they would otherwise be unable to do or increases the ease and safety with which tasks can be performed'.

Refer to Our Guidelines – Assistive technology on the NDIS website and Assistive Technology guidance on the Planning resources Intranet page.

5.3 Home modifications

Different types of home modifications may be funded by the NDIS. The NDIA defines standard (simple) home modifications as those that are non-structural and do not require local authority or other permits and classifies them at Complexity Level 3.

Complex Home Modifications (CHMs) require structural alteration to the building, may also require permits and are classified at Complexity Level 4.

Refer to Appendix D – Types of supports – Home Modifications.

5.4 Medium Term Accommodation

The participant may require temporary accommodation support as a result of their disability-related needs, whilst they transition to their desired long term accommodation arrangements. In these situations, Medium Term Accommodation (MTA) support can be added to plans to facilitate medium term transitional accommodation.

MTA needs to be considered reasonable and necessary to assist the participant to meet their longer term accommodation goals. Accommodation is considered transitional if it is temporary and assists the participant to transition to their permanent accommodation solution. MTA would generally be considered for periods of up to 3 months and can be reviewed for longer periods of time if required. Refer to the Our Guideline – Medium Term Accommodation for further information.

5.5 Individualised Living Options

ILO is a home and living support that lets the participant choose the home they live in and set up supports in the way that best suits them. ILO is the package of supports that can help the participant live in the way they want in the home environment they have chosen. It's not the home itself.

ILO supports help the participant to work out how they want to live, where they want to live and who they would like to live with. The participant can share their home with friends, housemates, live in the home of a host family or on their own with a variety of individualised supports.

ILOs are funded in two stages:

- **Stage 1 Exploration and design** - the first part is all about the participant exploring and designing the ILO support model that suits them.
- **Stage 2 Support Model** - the second part is funding to put those supports in place and monitor and adjust the supports as the participant's needs change.

There are examples of ILO arrangements in the ILO participant scenarios. There is also information available for participants and service providers on the NDIS website.

For information about making an ILO decision refer to Our Guideline – Individualised Living Options.

For information about how to include ILO supports in the participant's plan, refer to Appendix D – Types of Support – Individualised Living Options.

5.6 Supported Independent Living

SIL is assistance with and/or supervising tasks of daily life to develop the skills of individuals to live as independently as possible.

For further information refer to Providing Supported Independent Living (external) or Appendix D – Types of supports – Supported Independent Living (SIL).

6. Identifying suitable home and living solutions and support needs

Suitable home and living solutions can increase a person's quality of life and independence whilst reducing the need for funded supports.

The participant may identify a goal of finding suitable home and living solutions for a variety of reasons, which may include but are not limited to:

- identified risks (for example risk to self and/or others, homelessness)

- current housing is no longer suitable or sustainable, for example, the participant is at an age where it is more appropriate to live independently or they have ageing parents
- dissatisfaction with current housing, for example, residing in a nursing home, limited support network due to location
- current housing is unable to be modified to address functional limitations or to enable the provision of supports in a value for money manner
- current public housing residence is unable to be modified beyond the level of responsibility of the state housing authority.

6.1 Young people in voluntary out of home care arrangements

An assessment for SDA and SIL can be included in the plan for a 16-17 year old living under a voluntary out of home care arrangement.

In exceptional circumstances an assessment may be included for children 15 and under with General Manager approval.

Refer to Practice Guide – Children living in a formal voluntary arrangement outside their family home.

6.2 Who is responsible for identifying suitable home and living solutions?

The following people may be involved to identify suitable home and living solutions and gather required supporting evidence:

- The participant and/or their informal support network – where participants or their informal supports have the capacity and desire to coordinate any or all of Task 1 LAC or Support Coordinator or Task 2 Allied health practitioner below.
- LACs – if the participant is supported by an LAC, the LAC may provide assistance with identifying and coordinating of one or more of the tasks. Refer Task 1 – LAC or Support Coordinator.
- Support Coordinators – where the participant receives funding for a support coordinator, the support coordinator may provide assistance with identifying and coordinating required supporting evidence and justification. Refer Task 1 – LAC or Support Coordinator.

The NDIA requires sufficient supporting evidence and justification from suitably qualified AHPs. Refer to Task 2 – Allied health practitioner.

6.3 Funded supports which may be required

Funding for individual assessments and support coordination may be required when determining a participant's home and living support needs (refer to the table below).

Funding will be informed by the typical support package (TSP) and reasonable and necessary decision making.

The plan developer will need to include sufficient funding in the participant's plan to complete the relevant assessments. The Integrated Housing Team can provide advice about the assessments needed.

For information about how to include ILO supports in the participant's plan, refer to Appendix D – Types of Support – Individualised Living Options.

Support Type	Description
Coordination of Supports (07_002_0106_8_3)	To assist the participant with identifying and coordinating the required supporting evidence and justification as described in Task 1 – LAC or Support Coordinator and Task 2 – Allied health practitioner. Refer to Standard Operating Procedure – Include Support Coordination in a Plan
Assessment, recommendation, therapy and/or training (includes Assistive Technology) (15_056_0128_1_3)	To assist with obtaining relevant allied health practitioner assessments and reports. This includes justification for the identified home and living solutions and supports as described in the requirements of Task 2 – Allied health practitioner.

6.4 Compensation

Compensation, for NDIS purposes, is either a lump sum or periodic payment.

If you identify the participant is, or has been, entitled to compensation, update the responses in the risk assessment task in the system. Refer to the Compensation Recoveries intranet page for guidance on how to proceed. For further information refer to Our Guideline – Creating your Plan.

7. Plan Implementation and Monitoring

When the participant has a goal to explore and identify an appropriate home and living solution in their NDIS plan, the plan implementer must support the participant to achieve this goal by completing the following tasks/s when required:

7.1 Task 1 – LAC or Support Coordinator

If the participant identifies a goal of finding suitable home and living supports, the LAC or support coordinator is required to understand the NDIS legislation, reasonable and necessary decision making, NDIS Operational Guidelines, Pricing Arrangements and Price Limits and funding flexibility, as it applies to suitable home and living options.

You will need to complete the following tasks, which can include, but are not limited to:

- Ensure the participant understands what is contained in their NDIS plan and how they will be supported to explore and identify an appropriate home and living solution.
- Provide guidance on where the participant can access further information about the *National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020* (SDA Rules) and Our Guideline – SDA. With this information, the participant can learn what criteria are assessed when determining their eligibility for SDA. The information can also build the participant's understanding of reasonable and necessary decision making.
- Ensure the participant has adequate support whilst identifying a suitable home and living solution.
- Assess the adequacy of the supports that will assist the participant to remain living in their current accommodation.
- Where risk has been identified in a participant's current living situation, ensure the participant is linked with relevant allied health practitioners. Adequate supports must also be in place to sustain informal care until a home and living solution is identified.
- Collate the supporting information and assist the participant to complete the Home and Living Supports Request Form (external).
- Collate the Home and Living Supports Request form and any allied health professional assessments/documents and refer to the Integrated Housing Team so they can to identify the appropriate home and living response for the participant to pursue their goals.
- Help the participant with home and living applications (for example private rental, mainstream and public housing). If there is no immediately available accommodation, support the participant to manage their flexible budget and identify skill development and life transition planning strategies to prepare for future accommodation or home and living options.

- Inform the NDIA of any significant changes to a participant's circumstances, which may require a plan review. For example, change to current living situation, deteriorating condition, change to informal supports.

7.2 Task 2 – Allied health practitioner

Assessments are required to inform reasonable and necessary decision making and must be undertaken by suitably qualified practitioners, including Occupational Therapists (OT), Psychologists, Physiotherapists and Speech Therapists.

The plan developer may send a request for service form (for example the Request for Service – Specialist Assessment and Program) to the AHP. The form will help the AHP understand the requirements when supporting the participant to identify their home and living solutions. AHPs are required to perform the following tasks:

- Complete a comprehensive assessment of independent living skills, physical, sensory, neurological, cognitive and communicative needs, functional abilities and support needs.

  Note: not all of these assessments are required for every participant.
- Identify any potential risks to the participant's current living arrangement, informal care support, level of independence, social and economic participation. Provide recommendations to mitigate any potential risks, including how the recommended home and living solution will mitigate these identified risks.
- Identify suitable interventions, programs, strategies or skill development/capacity building opportunities that will help the participant maintain their current living arrangement and support them until a suitable home or dwelling becomes available.
- Monitor capacity building and skill development programs for the proposed home and living solution and provide a report in relation to the participant's progress/measurable outcomes.
- Identify the participant's informal support network and their ability to sustain their caring role, where applicable. Identify support needs, AT and/or home modifications, skill building and training needs to sustain informal supports and support the participant to remain in their current living arrangement, if this is appropriate.
- Identify the participant's home and living support needs, considering their capacity to live with others. Provide details of behaviours of concern, physical, cognitive and

sensory support needs, proposed and previously funded home modification and aides/equipment.

- Consider all types of suitable and comparable home and living options. For example, private rental, community housing, private residence and public housing.
- Consider any risks or additional support that may be required as a result of the participant moving to the recommended home and living solution. For example, choice of location may result in social isolation from community, informal support network, and local services and supports.

  Refer to Appendix B – Allied health practitioner.

7.3 Task 3 – Technical Advisory Branch (TAB)

Not all assessments and recommendations need to be forwarded to TAB for advice.

Participants identified as being suitable for private rental or social housing will continue to work with their LAC or support coordinator to identify appropriate home and living solutions, including the support required to live as independently as possible.

Check if the support requires referral to TAB for advice before including the support in the participant's plan. To check if TAB advice is mandatory and how to request advice refer to the TAB Requesting Advice intranet page.

The TAB will perform the following tasks:

- Review all assessments and supporting documents received by the regional site and submitted to TAB.
- Complete the Advice Request Process.

If a request for Home Modifications or AT requires TAB advice, a decision is made after receiving the TAB advice.

8. Appendices

8.1 Appendix A: Support Guide for Decision Makers – Identifying Home and Living Solutions

Type of Support	Supports generally funded by NDIS	Supports generally funded by OTHER PARTIES
Housing costs: Rent and utilities Whitegoods Moving house expenses	**Moving house expenses** May include support to pack personal belongings and domestic cleaning assistance, when the participant is unable to do this due to functional limitation (assessed on an individual case-by-case basis). Does not include removalist charges.	**Rent and utilities (including bond and property damage)** Considered day-to-day living costs normally met through disposable income (income support which is provided to assist participants with the cost of housing, including government pensions and allowances such as Rent Assistance). Explore general insurance options, however, this will be considered a 'deliberate act' and excluded in most policies. Explore general insurance options relating to accidental damage. **Whitegoods** Related to day-to-day living costs normally met through disposable income. **Moving house expenses** Including removalist costs which is an everyday cost normally met through disposable income.

Type of Support	Supports generally funded by NDIS	Supports generally funded by OTHER PARTIES
Accommodation	Long-term SDA accommodation where deemed reasonable and necessary by the Housing Assessor or Housing Panel. **Note:** transitional arrangements are in place for existing and in-kind SDA. Refer to Appendix C – Specialist Disability Accommodation.	Reasonable rent contributions by participants living in social housing or SDA in the form of 25% of Disability Support Pension. Government rent assistance. Affordable or social housing schemes.
Supports for child participants (under 18 years)	**Disability related supports** Supports specific to a child's disability additional to the needs of children of similar ages. Includes assistance with daily personal activities, AT, capacity building, community participation and home modifications. **Disability specific parenting training programs** Specifically designed for the participant's needs and are not available as a mainstream service. This can include intensive training such as one-on-one or in-home training for parents, specific to a participant's disability. Disability related transitional supports for 17 year old participants to prepare for transition to living independently as an adult.	**Parental responsibility** The Agency does not replace what is considered parental responsibility, when considering the support needs of children of similar ages. **SIL and SDA related supports** The NDIS generally only provides SDA or SIL for participants aged 18 years and over. Parents are responsible for providing daily care, support and supervision for children under 18 years of age. For young people in voluntary out of home care arrangements please refer to 6.1 Young people in voluntary out of home care arrangements. For children in statutory out-of-home care (Child Protection), the relevant state authority holds parental responsibility and

Type of Support	Supports generally funded by NDIS	Supports generally funded by OTHER PARTIES
		as such, is responsible for providing daily care, support and supervision for children under 18 years of age. **Housing and accommodation for children** The NDIS generally only provide SIL and SDA for participants aged 18 years and over. Parental responsibility includes the provision of housing and accommodation for children under 18 years of age.
Supported Independent Living (SIL)	**Holidays/overnight stays** No additional funding is included for supports during holidays/overnight stays. Participants are required to use their SIL budget and negotiate inclusions with their provider. **Stand-up shifts and sleepovers** No additional funding is included for stand up-shifts and sleepovers. Participants are required to use their SIL budget and negotiate inclusions with their provider. If there has been a significant change to the participant's circumstances/needs, then a plan review should be initiated to consider the participant's SIL support needs. **Non-participant residents**	**Vacancies within the property** The Agency **does not** fund vacancies. Funding is based on number of bedrooms and shared support. It would not be appropriate to approve a change of circumstances (s48) plan review to change the ratio of the SIL to accommodate the provider's vacancy. It is the provider's responsibility to fill any vacancy.

Type of Support	Supports generally funded by NDIS	Supports generally funded by OTHER PARTIES
	Funding is based on bedrooms and shared supports. For example, where a person who does not receive NDIS supports shares a house with NDIS participants and shares the core roster of supports, we fund a ratio which includes the non-participant. The support needs of the non-participant are not funded, but their care needs are considered when determining the ratio.	

8.2 Appendix B – Allied health practitioners to support home and living needs

Participants may require various assessments to determine their functional abilities and the support they may require to assist transition to alternate accommodation, once a home and living solution is identified. It should also be recognised that a participant may have current information from previous assessments that may be suitable to use to determine support needs.

The assessments will determine the participant's current capacity and support needs and will inform the support required to remain in their existing home or to transition to a new home. Assessments will report on any risks to the participant or others and will identify skill development and capacity building opportunities.

The different types of AHPs who may be engaged to support the participant with determining suitable home and living support needs has been described in more detail below.

8.2.1 Occupational therapist

An OT undertakes an assessment showing the functional capacity of an individual and recommends interventions to support the participant to achieve goals and promote independence. These interventions can relate to:

- changes to the environment (for example, home, work or community)
- to the way the task is undertaken (for example, the use of AT or alternative methods)
- capacity building for the individual (for example, skills, knowledge).

An OT can design and coordinate individual programs to support a participant's independence in everyday activities and provide strategies to maintain a safe home, work and social environment to suit the needs of the individual. For a participant an OT can:

- develop coping strategies to help overcome mental health issues
- improve confidence and self-esteem in social situations
- monitor function and progress, prescribing AT for individuals when required.

OTs with appropriate skills and experience (eligible for registration in the NDIA Specialist Behaviour Support registration group) can also provide sensory assessments for participants. Sensory assessments may be required for participants with a primary disability of autism with identified positive behaviour support needs and where intellectual disability, complex communication requirements (participant communicates indirectly or unintentionally) or major mental illness is present.

A sensory assessment provides an enhanced understanding of the way the participant with these characteristics experiences the world, such as:

- heightened reactivity to sound, touch or movement

- difficulty accepting changes in routines or transitioning between tasks
- poor sleeping patterns
- distractibility
- poor motor skills or preference for increased amounts of input to sensory systems - auditory, tactile or movement.

These characteristics may underlie observed behaviour. A behavioural assessment from a psychologist and a communication assessment from a speech pathologist, may assist in the development of appropriate management strategies including capacity building for the person and their support network.

Assessments and capacity building strategy recommendations could include, but are not limited to:

- Activities of Daily Living (ADL) assessment (all participants requesting support with SDA)
- General Living Skills or Functional Capacity Assessment (all participants requesting support with SDA)
- balance and mobility assessment (as part of the Functional Capacity Assessment)
- AT and home modifications assessment, including current and proposed needs as they relate to new home and living options, where a participant has a functional impairment or mobility support need
- sensory assessment (autism and intellectual disability)
- Behaviour Support Assessment (in conjunction with a psychologist). Focus on environmental modifications related to positive behaviour support.

8.2.2 Psychologist

A psychologist will undertake a functional behavioural assessment for a participant who has behaviours of concern (BoC), and will consider everyone involved in the participant's life. The assessment will inform the behavioural intervention supports required and will support the development of a Behaviour Support Plan (BSP). The BSP will provide strategies and detail supports required to develop the skills of the participant and the people around them. The aim is to promote a supportive and positive environment to reduce the frequency and intensity of BoC.

The development of a BSP requires specialised skills that can only be provided by qualified behavioural professionals, therefore funding in the participant's plan must be entered in to the

System as a 'Stated Support'. A copy of the BSP and any other assessments completed need to be attached to the participant's record in the System.

If a participant has a current BSP, a review request to a psychologist should be made to ensure all identified BoC have strategies and recommendations to support the participant and carers in their new and existing environments.

8.2.3 Speech therapist (also known as a speech pathologist)

A speech therapist is able to assess the development and disorders of communication and swallowing. A communication assessment will provide a comprehensive assessment of a participant's communication skills and explore receptive, expressive and pragmatic language, articulation, literacy and fluency of speech. The assessment supports participants who have difficulty expressing themselves and would benefit from capacity building support to assist their communication and learning development.

Participants who have complex communication needs (those who do not appear to communicate directly in a conventional manner) can also benefit from a communication assessment. For these participants, assessments provide support with communication in daily life (including AT where appropriate), provide information to psychologists involved in the development of behavioural management strategies and can result in improved relationships and quality of life.

For participants who have a swallowing disorder, a speech therapist may recommend specific swallowing treatments and exercises to improve muscle movement to support the participant to swallow more effectively. A speech therapist may also consider specific foods and liquids that may be easier to swallow.

Note: The assessment and diagnosis of a swallowing disorder is not an NDIS funded support.

A speech therapist will also provide guidance to support workers or informal supports to assist in implementing and maintaining the treatment plan.

If there are concerns about the nutrition and related health of the participant who needs a modified diet related to their disability for swallowing, then a certified practicing dietitian may be asked to provide an assessment.

8.2.4 Physiotherapist

A physiotherapist provides an assessment which supports the mobility, transfer and equipment needs, recommending suitable self-managed exercise programs to maintain functional mobility. The focus is on the participant's general functional ability to move about over different types of ground and environments, with an emphasis on the community. A physiotherapist normally:

- considers features such as stairs, ramps, uneven ground, transfers in and out of furniture or vehicles
- identifies suitable mobility AT to support maximal function in different environments
- advises safety precautions.

The assessment report should provide information about factors including balance, strength, endurance, range of movement, stability, coordination, reaction time and whether functional capacity fluctuates over the day or in certain circumstances. A physiotherapist will also consider the influence of coexisting issues such as vision, hearing and cognitive problems, for example, decreased concentration, difficulties with planning and problem-solving and inattention to left or right. This information, together with an assessment by an OT to consider the requirements for a suitable home and living solution, should be taken into account.

Assessments are aimed at those who use mobility aids and where assistance may be required due to progressive deterioration of balance and mobility.

A physiotherapist is able to review and monitor prescribed exercise programs (including hydrotherapy) and will develop support worker training to support the participant to maintain their functional mobility.

Note: The participant will require ongoing reviews with the physiotherapist to monitor their outcomes against their individual goals and the physiotherapist will implement changes to any programs or treatment needed.

8.3 Appendix C – Specialist Disability Accommodation

SDA can only be determined as a reasonable and necessary support for participants with extreme functional impairment or very high support needs. Other home and living options should be considered and explored as part of determining the reasonable and necessary supports for a participant. The combination of SDA and other supports must provide greater benefit in pursuing a participant's goals and outcomes, and represent value for money compared to other options.

SDA is intended for participants where their accommodation needs and the supports within the home cannot be met by the types of housing available in the general market.

The SDA Rules and Our Guideline – SDA provide further guidance on how participants, providers and their dwelling are considered and managed by the NDIS.

SDA is capital funding the participant will receive in their NDIS plan for the SDA dwelling in which they live. Any other NDIS funded supports that may be provided within the dwelling are funded separately to the SDA and through a separate service agreement to the SDA.

SDA is only expected to be funded for a very small portion of participants, around 6% (or 28,000 at full NDIS capacity) is the current estimate.

If SDA funding is included in the participant's plan, it is expected this will assist in meeting the long-term outcomes for the participant and not be used as a transitional support. SDA payments to providers are made at the equivalent rate related to the type of SDA as shown in the participant plan. It is not made based on the current accommodation price for the dwelling, unless the two are equal, (that is, where there is a difference between the participant is found eligible for and the rate the dwelling is enrolled for, the lower price is paid).

There are a range of SDA building types and design categories specified in the SDA Rules and SDA Pricing and Payments. The building types range from a single resident apartment to a group home for five residents. The SDA design categories are: Improved Liveability, Fully Accessible, Robust or High Physical Support.

The NDIS will consider the participant's current living arrangements, their goals and aspirations in determining if SDA is appropriate. Therapeutic assessments will provide the evidence to further support the planning decision.

When it is identified that SDA is the most suitable home and living solution, the planner must complete a Home and Living Application to be considered by the Integrated Housing Team.

Participants with SDA in their plan may be requested to make reasonable rent contributions to their SDA providers. This is capped at 25% of the base rate of the Disability Support Pension, plus any other government rent assistance payments received. SDA payments are paid to SDA providers through the plan and are separate to the participant rent contribution.

8.3.1 A new SDA decision

When the participant wishes to move in to SDA for the first time or wishes to move to a different SDA dwelling, from an existing or in-kind SDA dwelling, this is considered to be new SDA.

For new SDA, the SDA support funding must not be included in the participant's plan without referral for a home and living application decision.

The Integrated Housing Team representative or the Housing Panel will review the participant's SDA eligibility and provide a decision for the participant's Home and Living request. If the participant is eligible for SDA the home and living application decision will include information on the eligible SDA type and level for the participant. This information is recorded in the Housing and Accommodation section of the participant's record.

Refer to the Standard Operating Procedure – Create a Home and Living Application.

8.3.2 Existing or In-Kind SDA

When the participant is already residing in an SDA dwelling when they transition to the NDIS they are considered to be in existing or in-kind SDA. SDA funding needs to be included in the participant's NDIS Plan. Refer to:

- Standard Operating Procedure – Include Specialist Disability Accommodation (SDA) supports
- Standard Operating Procedure – Adding In-Kind Supports in a Plan.

8.3.2.1 Participants transitioning to the NDIS

During transition, all participants already in disability related supported accommodation which has been funded by either State, Territory or Australian Governments will be considered to meet the eligibility criteria for including SDA in their plan. The level of SDA funding approved will be at the same level required to match the enrolled SDA dwelling they already live in. Many existing dwellings are considered **Basic**. According to SDA rules, basic cannot be considered to be a participant's appropriate SDA. As a result, many participants will be found to require a different (higher cost) SDA if they are assessed with the intention to move.

Note: It is not expected that the participant once found eligible for SDA, would lose that eligibility. Participants are eligible for SDA if they cannot live in mainstream housing because of:

- an extreme functional impairment
- very high support needs
- their needs are most appropriately met by SDA.

8.4 Appendix D – Types of supports

8.4.1 Assistive Technology

AT is defined by the World Health Organisation as 'any device or system that allows individuals to perform tasks they would otherwise be unable to do or increases the ease and safety with which tasks can be performed'.

For information on including AT supports in the participant's plan refer to Our Guidelines – Assistive technology on the NDIS website and Assistive Technology guidance on the Planning resources Intranet page.

8.4.2 Home Modifications

For all Home Modifications, the participant must involve a therapist who is suitably experienced and qualified to complete these assessments.

Complex Home Modifications are changes to the structure, layout or fittings of the participant's home and are required to enable the participant to safely access and move around their home. **All Complex Home Modifications need to be referred to the TAB for reasonable and necessary advice prior to progressing the quoted modification.** Refer to the TAB Home Modifications intranet page.

It is expected a home modification would only be considered where the home to be modified is the participant's primary residence and the participant intends to remain living at the residence.

8.4.2.1 Public and community housing home modifications

Remain the responsibility of the relevant state/territory and are not funded by the NDIS.

8.4.2.2 Home ownership home modifications

Participants and families who own their own home may have home modifications funded through the NDIS if deemed reasonable and necessary.

8.4.2.3 Shared equity home modifications

Where allowable under the agreement, home modifications may be funded through the NDIS if deemed reasonable and necessary.

8.4.2.4 Private rental home modifications

If home modifications are required in a rental property, written agreement from the owner of the property is required before the NDIS would consider funding reasonable and necessary home modifications.

8.4.2.5 SDA home modifications

The NDIS generally does not fund home modifications in properties owned or leased by SDA providers. The reason for this is that the SDA provider is responsible to provide a suitable physical environment for their clients.

Refer to Standard Operating Procedure – Include Home Modification Supports in Plans or Complex Home Modifications Assessment Template.

8.4.3 Capacity Building – Skill Development

If the TSP has generated funding for Capacity building – daily life supports (e.g. individual therapy assessments), this funding should not be removed from the budget and can be used to complement identifying home and living solutions if required. For example, funding generated by the TSP may be used to support the participant in developing their skills for self-care tasks as they await suitable housing.

8.4.4 Individualised Living Options (ILO)

ILO supports are included for the participant in two stages. Generally, you will only include what is reasonable and necessary for the support model once Stage 1 is complete.

8.4.4.1 Stage 1: Exploration and Design

The first stage is all about the participant exploring and designing their ILO. During this time the participant works with their family, friends and/or chosen provider to:

- work out where they want to live
- what support they will need
- who they want to provide the support
- complete a Service Proposal form.

To work out what Exploration and Design supports are reasonable and necessary refer to Our Guidelines – Individualised Living Options.

To include ILO Stage 1 supports in the participant's plan, refer to Standard Operating Procedure – include ILO Stage 1: Exploration and Design.

8.4.4.2 Stage 2: Support Model

The second stage is putting the ILO supports in place. Stage 2 Support Model includes funding for:

- Primary supports
- Supplementary supports, and
- Monitoring and adjusting supports if the participant's needs change.

To work out what Support Model funding is reasonable and necessary refer to Our Guidelines – Individualised Living Options. To include ILO supports in the participant's plan, refer to Standard Operating Procedure – include ILO Stage 2: Support Model.

8.4.5 Supported Independent Living

SIL is assistance with and/or supervising tasks of daily life to develop the skills of participants to live as independently as possible.

The NDIS generally only provides SIL for participants aged 18 years and over. Funding SIL for children under the age of 18 years would only be considered in exceptional circumstances. All providers will be required to use the new SIL pack and quoting tool when submitting quotes for these services.

The SIL pack and quoting tool and template will ensure a more efficient and nationally consistent process and is intended to result in provider quotes being assessed in a timely and responsive manner.

Refer to the Provider SIL pack and Standard Operating Procedure – Include Supported Independent Living (SIL) in plans.

9. Supporting material

- NDIS Act 2013
- NDIS Rules
- Planning Operational Guideline
- Our Guideline – Specialist Disability Accommodation (SDA)
- Our Guideline – Medium Term Accommodation
- Our Guideline - Individualised Living Options (ILO)
- Our Guide – Supported Independent Living

10. Feedback

If you have any feedback about this Practice Guide, please complete our Feedback Form.

11. Process owner and approver

General Manager Participant Experience Design.

12. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
18.0	CW0032	Class 1 approved. Updated links to assistive technology guidance.	APPROVED	2020-12-10
19.0	BIB217	Updated information for Specialist Disability Accommodation (SDA). Includes Housing Applications created in the ACE Business System, the role of the Operational Housing team and Housing Panel process. Update Assistive Technology link to external Our Guidelines. Content endorsed by Operational Housing Branch Manager Performance Management and Quality. Class 3 approval	APPROVED	2020-12-27

Version No	Amended by	Brief Description of Change	Status	Date
20.0	JS0082	Added content to Specialist Disability Accommodation section from approved Practice Guide – Determine the Reasonable and Necessary Supports (26.0) due to be retired 1 March 2021. Class 1 Approval	APPROVED	2021-02-12
21.0	CW0032	Include information for Individualised Living Options (ILO). From 26 April 21: • Our Guideline – ILO scheduled for release • Practice Guide – ILO scheduled to be retired. Class 2 approval	APPROVED	2021-03-03
22.0	JS0082	Class 1 – Approval Update name of Integrated Housing Team. Minor language change from housing to home and living	APPROVED	2021-04-28

Practice Guide – Safeguarding the participant's interests

Contents

1. Purpose

This Practice Guide will support you to understand how we safeguard the participant's interests on a day-to-day basis as they engage and connect with the NDIS.

This includes understanding where to locate information to assess and report risks though the NDIA Issues and Incident Management Framework and Participant Critical Incidents Framework.

Note: Check you have read and understood the Participant Experience Delivery (PED) Key Performance Indicators (KPIs) and are complying with the PED KPIs and target relevant to this Practice Guide.

2. To be used by

This Practice Guide is for use by all staff of the National Disability Insurance Agency (NDIA), with a particular focus on staff in service delivery including:

- Plan Developers – Planners and NDIS Partners in the Community (PiTC - Early Childhood Partners and Local Area Coordinators [LACs])
- NDIA Plan Delegates
- Payment Analysts
- Business Support Officers (BSOs)
- National Contact Centre (NCC)
- National Complaints Resolution Team (NCRT) - including National Escalations Team (NET)
- Member and Senator Contact Officer (MASCO)
- Ministerial Coordination Team.

3. Scope

This Practice Guide considers the frameworks that underpin the safeguarding of the participant's interests by addressing:

- the context of the NDIA within the broader framework
- the programs within the NDIA to address risks to the participant
- how conversations with the participant, their nominee or child representative may highlight safeguards as they engage with the NDIA.

4. Context in the Broader Framework

4.1 Quality and Safeguarding Framework

The NDIS represents a fundamental change to how people with disability receive support across Australia. To support providers and the community to be ready for this change, the Department of Social Services NDIS Quality and Safeguarding Framework (external) was developed. This framework provides a national approach to empower the participant to exercise choice and control, with appropriate safeguards in place, and establishes expectations for providers to deliver high quality services.

The NDIS Quality and Safeguarding Framework underpins the NDIS Quality and Safeguards Commission (external) which is responsible for receiving and investigating allegations of reportable incidents. Reportable incidents are serious incidents or allegations which result in harm to an NDIS participant and happen in connection with NDIS supports and services. Refer to section 6.1 NDIA Participant Critical Incidents Framework for more information about the Participant Critical Incident process.

If the participant is a younger person in residential aged care, you may also need to report to the Department of Health – Aged Care (external). This is communicated to the participant by the NDIA.

4.2 National Disability Services Zero Tolerance Framework

The National Disability Services Zero Tolerance Framework (external) was developed to help providers understand actions they can take to prevent and respond to abuse, neglect and violence of people with a disability. This includes resources for provider staff to understand their responsibilities in preventing and responding to abuse and to reinforce the human rights of people using disability services.

4.3 The National Disability Abuse and Neglect Hotline

The National Disability Abuse and Neglect Hotline (external) (the Hotline) provides national access for the reporting of abuse and neglect of people with disability. The Hotline works to promote fair and just treatment of people with disability to achieve social justice, equality and the same rights, responsibilities, opportunities, access and participation as other people in Australian society.

For critical incidents in the home or community setting, escalation and reporting via the Hotline is recommended. The Hotline can provide referral and linkages to the most appropriate agency to investigate and address the report.

The Hotline is closely aligned with the Complaints Resolution and Referral Service (CRRS), outlined below.

4.4 Complaints Resolution and Referral Service

Complaints to the CRRS (external) can be made by clients of services funded by the Department of Social Services (DSS) under the *Disability Services Act (1986)*. These services include:

- Disability Employment Services (DES)
- Australian Disability Enterprises (ADEs)
- Advocacy Services (funded by DSS).

5. NDIA Context and Background

5.1 NDIA Incident Management Frameworks

The NDIA Issues and Incident Management Framework consolidates the NDIA incident response when considered with the Participant Critical Incident Framework. The Issues and Incident Management Framework creates a documented, streamlined approach and is aligned to the NDIA risk management cycle.

The Issues and Incident Management Framework details the requirements for managing issues in a consistent, methodical, risk based approach. For more information, refer to the Welcome to Risk intranet page.

The Participant Critical Incident Framework is designed to assist NDIA staff and PiTC to determine the necessary and appropriate actions to undertake when they are made aware of a participant critical incident.

A report of a **participant critical incident** is any information provided to the NDIA that alleges:

- the death of an NDIS participant
- serious injury of an NDIS participant
- abuse or neglect of an NDIS participant
- unlawful sexual or physical contact with, or assault of, an NDIS participant
- sexual misconduct committed against, or in the presence of, an NDIS participant, including grooming of the NDIS participant for sexual activity
- the unauthorised use of a restrictive practice in relation to an NDIS participant
- an NDIS participant threatening or attempting self-harm.

A participant critical incident allegation may involve any stakeholder including NDIS registered providers, NDIA staff, informal supports, family or other person/s.

Participant critical incidents which relate to unreasonable behaviour of the participant, or other third party, should be managed by NDIA staff and PiTC consistent with the NDIA Managing Unreasonable Behaviour Framework, Policy and Guideline. This includes information, advice, reporting and escalation protocols in circumstances where the health, safety or security of staff, partners or others is placed at risk.

5.2 Reportable Incidents

The NDIS Quality and Safeguards Commission (NDIS Commission) is responsible for receiving and investigating allegations of reportable incidents. Reportable incidents are serious incidents or allegations which result in harm to an NDIS participant and occur in connection with NDIS supports and services.

Registered NDIS providers in all states and territories, except Western Australia, are required to notify participant critical incidents that relate to services and provisions provided by a registered provider. Notification is to be made to the NDIS Quality and Safeguards Commission, under s73Z of the *National Disability Insurance Scheme Act 2013 (NDIS Act)* and Part 3 of the *NDIS (Incident Management & Reportable Incidents) Rules 2018*. For further information about participant critical incidents which are notifiable to the NDIS Commission, refer to NDIS Quality and Safeguards Commission (external).

5.3 Critical Services Issues Response

Each state and territory, together with the NDIA and DSS, have signed a Critical Services Issues Response (CSIR) agreement to manage the escalation of critical issues that impact on an individual, primarily a NDIS participant.

The CSIR is a process for coordinating the escalation of complicated and intractable matters impacting on an NDIS participant that cannot be resolved at the local level. Matters include issues, which relate to mainstream services including but not limited to the following:

- health and mental services
- early childhood education
- child protection and family support
- school education
- vocational education and training
- social housing
- public transport
- justice, including corrective services.

6. Critical Incidents in the Home or Community

People with disability are among some of the most vulnerable people in society and have the right to freedom, respect, equality and dignity. They have the right to live to their full potential, to have control over their own life and to live free from abuse or neglect.

Violence can be physical, sexual, intimidating or forceful. People with a disability may experience violence from a carer or family member. This can occur in the home or a community setting. Abuse is when actions violate another person's human rights and can be physical, mental, psychological, sexual or financial.

Neglect is the failure by a service provider or person caring for a person living with a disability to provide adequate care.

Escalation and reporting via the National Disability Abuse and Neglect Hotline (external) is recommended for critical incidents in the home or community setting. Referral and linkages may be provided to the most appropriate agency to investigate or address the report. The principles outlined in the Participant Critical Incident Framework should be followed to make contact with the Hotline and escalate to a line manager before any report is made. After escalation and full consideration it may also be necessary to make a police report.

Note: The Hotline is not a crisis service. Life threatening services should immediately be reported to emergency services by calling 000.

There may be situations where allegations are made regarding critical incidents involving NDIA or Partner staff. All Australian Public Service (APS) employees are required to comply with the APS Code of Conduct and APS Values and Employment Principles. Refer to the Australian Public Service Commission (external) for more information.

There is a duty to report inappropriate behaviour and suspected misconduct. Perceived inappropriate behaviours or allegations received about a staff member should be discussed with or reported to a senior manager. The matter can also be discussed with People and Culture.

Partner staff are expected to share the NDIA values however are not direct APS employees. PiTC are independent organisations with their own employment guidelines, policies and processes. As a PiTC, there is a contractual obligation to report serious complaints regarding staff, breaches or incidents. Under the NDIA Issues and Incident Management Framework this information is reported and investigated by the NDIA.

6.1 NDIA Participant Critical Incidents Framework

The Participant Critical Incidents Framework details your roles and responsibilities when you suspect or receive information about an alleged critical incident including abuse, neglect or exploitation. Anyone can report a critical incident to the NDIA, including Partner staff.

The Participant Critical Incidents Framework helps you to determine the appropriate action to take when you suspect or obtain information, indicating a critical incident or situation of concern for a person with disability who may be subject to abuse, neglect or exploitation.

This Framework compliments the broader NDIA Issues and Incident Management Framework, which uses a risk based approach to provide overarching guidance to managing issues and incidents in a consistent and methodical manner.

In responding to reports of critical incidents, the NDIA and PiTC may disclose information to relevant authorities such as police or child protection services if:

- the consent of the individual is obtained (s60(2)(d)(iii) of NDIS Act)

- staff have reasonable grounds to believe that the disclosure is necessary to prevent or lessen a serious threat to the individual's life, health or safety (s60(2)(e) of NDIS Act).

6.2 Exceptionally Complex Support Needs Program

The Exceptionally Complex Support Needs Program (ECSNP) is designed to contribute to growing market and community capacity and capability to support participants with exceptionally complex support needs.

The ECSNP has been designed to enable the NDIA to respond to participant crisis situations that cannot be supported by regular NDIA functions, including the CSIR and Complex Support Needs Pathway.

The ECSNP has three functions:

- **Sector and Community Development and Delivery Activities**

  This includes workshops, training sessions and individual engagement with mainstream and community services (such as health services, justice services). The aim of these activities is to support the growth and capability of people working with participants with complex support needs. This work will also build capabilities, knowledge and skills of NDIS providers who work directly with participants with complex support needs.

- **Subject Matter Expertise Activities**

  This includes providing guidance and advice to services for specific issues related to providing support for people with exceptionally complex support needs. The Program Providers will also be able to provide skilled support coordinators to support a participant if required.

- **Crisis Referral Activities**

  This is for approved referrers (key emergency service responders) and will only accept referrals for participants over 18 years.

Approved referrers to ECSNP include:

- Key emergency services organisations
  - State police services
  - State ambulance services
  - Hospitals (public and private)
- Acute state mental health services
- Australian Federal Police
- State justice officers.

6.3 Other key resources

Refer to section 13 Supporting material for a list of other key resources.

7. Safeguarding the participant's interests

7.1 Assessing risks and safeguards

Assessment of risks and safeguards occurs throughout the planning process, as outlined in the Planning Our Guideline – Performing a support needs assessment. A support needs assessment involves:

- reviewing existing information
- conducting a planning and assessment conversation
- requesting further information or reports to inform a participant's plan, where necessary
- assessing risks and safeguards.

A general principle which guides actions under the NDIS Act is the support of people with disability to exercise choice in the pursuit of their goals and the planning and delivery of their supports. This includes taking reasonable risks.

One of the NDIA's functions is to ensure that a reasonable balance is achieved between safety and the right of the participant to choose to participate in activities involving risk, as stated in Section 118(1)(a)(v) of the NDIS Act.

The NDIA manages risk by putting in place reasonable safeguards, which balance the safety of the participant with the risk of harm, while imposing the minimum necessary restrictions. This allows a participant to exercise choice and the control over their life and recognises their ability to take reasonable risks and make reasonable mistakes.

The planning and assessment conversation with the participant provides an opportunity for open discussion during the development of their plans. Actual and potential risks may be identified and a range of safeguards and support mechanisms explored, particularly in the following ways:

- **Choice and control** - The participant is empowered to make their own decisions about their supports and the management of their funding arrangements.
- **Risk-based and person-centred approach** - Safeguards are proportionate to the actual level of risk the participant faces, based on their functional capacity, natural support network and the supports available to them.
- **Presumption of capacity** - The participant is presumed to have the capacity to exercise choice and control and support will be provided to develop and exercise this capacity.

The participant is encouraged to develop their own strategies and safeguards to reduce their potential exposure to harm or to manage the exposure. The following levels of safeguards can be used as a guide in the development of appropriate measures:

- **Individual level safeguards** – informal and formal safeguards for the participant:
    - Informal safeguards acknowledge the participant is more likely to be safe when they are actively involved with their family and the community. The things that make people safe can be seen as the same things that are needed to have a good life. For example, caring relationships and enhanced opportunities for participation in daily life.
    - Formal safeguards include rules for restrictive practices and serious incident reporting.
- **Service level safeguards** – This includes quality frameworks, complaint mechanisms and workforce requirements such as qualifications, recruitment practices and performance standards. For many providers, having appropriate service level safeguards will be one of the requirements for registration with the NDIA.
- **System level safeguards** - The NDIA will use existing system level safeguards to protect the participant. These include internal and external processes for making complaints, processes to have decisions reviewed by an independent body and statutory power.
- **Community based safeguards** - The NDIA uses and operates in the context of existing community-based safeguards that are not formally a part of the disability service system. These include advocacy organisations, community visitor schemes, public advocates or guardians, ombudsman offices and discrimination commissioners. People with disability can also use a range of community safeguards including anti-discrimination and consumer protection legislation.

Additional safeguards that can be included in the participant's plan are:

- setting a shorter period between plan reviews
- establishing arrangements for regular contact between the NDIA and the participant
- providing funding for supports to assist the participant in managing their own plan, for example, budget training.

7.2 The planning process

The assessment of risks and safeguards occurs during contact with the participant as they develop their plan. The plan developer should review streaming factors to ensure the participant receives appropriate assistance to participate in this process. Relevant information is considered and recorded using the following tools and processes in the NDIS Business System (System):

- participant streaming tool
- planning conversation tool and the actual planning conversation
- risk assessment
- informal, community and mainstream supports
- determine reasonable and necessary funded supports
- determine plan management.

Safeguards include facilitating the participant to be supported in their decision making and/or interactions if they require that level of support. The participant may be appointed a plan nominee, correspondence nominee, or be supported by a third party with authority or consent.

8. Access

The National Access and Reviews Branch (NARB) assesses risks and implements safeguards as a fundamental part of the access process. Each step in the access process includes strict requirements and standards for processing and assessing an access request. Quality Control is inbuilt into work practice to mitigate risk and safeguard the participant prior to an access decision being finalised. The resources listed below allow staff to follow comprehensive procedures at each part of the process:

- Task Card – Verbal Access Request (VAR)
- Staff Manual – Access and the NDIS for all staff
- Staff Resource – Types of documentary evidence – Age & Residence
- Staff Manual – Access information gathering for Access Officers
- Task Card – Enter the Access Request Form
- Staff Manual – Access Decision Making for Access Assessors
- Quality Control Audit Guide
- NDIS Business System: NAWMB Security Roles

9. Pre-planning

The following sections highlight the areas of pre-planning where there is opportunity to discuss and develop safeguards to ensure the participant's interests are considered, risks identified and mitigated where necessary.

Take the example of the participant who lives in public housing with inadequate bathroom facilities that do not meet the relevant codes and standards. This information is highlighted when completing the functional assessment questions. They require some support with self-care tasks however they experience additional difficulties because the bathroom is inadequate. Actions that may be taken are to:

- consider reasonable and necessary support to assist with self-care, which may include assessment and reporting to be included in the plan
- in the System, record in the informal, mainstream and community support task the participant's mainstream housing circumstances
- discuss with the participant and the avenues that may be followed with the mainstream housing supplier
- inform the plan implementer (support coordinator or PiTC) of the funded and mainstream support requiring follow up.

9.1 Streaming

In the System, streaming can be updated at any point in the pathway. Based on how the participant is streamed, they will be provided with the appropriate level of support to engage in the development of their plan. For example, the participant may have one or more Super Intensive streaming factors. The Super Intensive streaming results in plan development with an NDIA planner and the inclusion of a support coordinator to support the implementation of the plan. In this way, participant streaming levels safeguard the participant by ensuring appropriate resourcing and expertise.

The participant may also be referred to the Complex Support Needs Pathway for additional support. As circumstances stabilise for the participant and this safeguard is no longer required, they may exit the Complex Support Needs Pathway. A handover of information should occur so the participant is supported in the generalist pathway.

For more information, refer to the Standard Operating Procedure – Update Participant Streaming.

Note: The term streaming is for internal use only.

9.2 Primary disability

It is important the correct primary disability is recorded in the System. This means the appropriate disability severity indicator tool for the participant's disability is generated and completed. This helps inform the Typical Support Package (TSP) to better reflect supports

needs. The TSP is the starting point of support the participant may require. Secondary disabilities and impairments should also be considered to support a 'whole of person' approach to the participant. By using reasonable and necessary decision-making for the participant's disability-related supports you are using a measure which potentially protects the participant from risk.

For information on how to change the participant's disability post access, refer to the Standard Operating Procedure – Change Disability (Post Access).

9.3 Severity Indicator Tool

Functional capacity assessment information (known in the System as severity tools) may be provided by the participant as a professional report, or may be a tool completed by the plan developer with the participant. It is used to assess the level of impact the participant's disability has on their daily activities. This information may highlight a risk to the participant and can help inform other aspects of the planning process where both risks and safeguards are recorded.

For more information, refer to Standard Operating Procedure – Complete the Update the Severity Tools task.

9.4 The participant statement

The participant statement captures the environmental and personal context of the participant. Through discussion of the living arrangements, relationships and goals, the participant's interests guide the planning process. The participant's long and short term goals and how they will be supported to achieve their goals is recorded. Where appropriate, safeguard information may be recorded in this section. For example, referral to family support services and child learning programs may be required to reach a family orientated goal.

For more information, refer to the Planning Our Guideline – The participant's statement of goals and aspirations and the Standard Operational Procedure – Complete the Participant Statement.

9.5 Informal, community and mainstream supports

Mainstream and community supports are available to all members of the community regardless of whether they have a disability or not. Supports captured in the informal, community and mainstream supports tool highlight areas where support may be required or unsustainable. The participant may have areas of their life which require involvement of mainstream services to provide additional support. For example health services, housing, child protection and mental health services.

The level and availability of informal support and what is reasonably expected of families are considerations for determining reasonable and necessary supports included in the plan. By understanding the natural supports of the participant you may safeguard the participant by:

- determining where funded support is not necessary to replace or disrupt a support provided informally
- understanding where someone who provides informal support may need support or referral to another service
- identifying where additional supports in the plan are reasonable and necessary due to informal support being unavailable, changing or otherwise.

For more information, refer to the Standard Operating Procedure – Discuss and Record Informal, Community and Mainstream Supports.

9.6 Risk assessment and plan duration

When developing the plan, the risk assessment should be used to identify risks and record safeguards in the participant's life. This is done by asking questions of the participant or their authorised representative as well as recording information gained from the overall planning conversation and available supporting evidence. Information is recorded in the risk assessment in the following areas:

- Plan Management Request
- Compensation
- Plan Duration
- Safeguards – Informal Supports
- Participant Vulnerability
- Decision Making Capacity
- Capacity and Interests of Nominees or Child Representatives.

The plan duration is determined when completing the risk assessment tool. This follows on from a conversation with the participant or their authorised representative regarding life changes the participant is expecting to make over the next three years such as leaving school, starting or leaving work, or a change to their living situation.

Shorter plan durations may be implemented in response to situations where the participant is experiencing higher risk, until their condition stabilises. For example, while the participant undertakes rehabilitation and function reaches a stable level.

For more information, refer to the Standard Operating Procedure – Complete the Risk Assessment task.

9.7 Planning conversations for complex needs

The Complex Support Needs Pathway exists for the participant experiencing additional obstacles requiring a high level of support to engage in the development and implementation of their plan. This may result in a higher level of support provided to coordinate multiple services and support the development and implementation of the plan.

For more information, refer to the Practice Guide – Complex Support Needs Pathway.

9.8 Representation by nominee or party with consent/authority

Nominees are appointed in circumstances where the participant is unable to make decisions independently and does not have informal or formal support networks to support their decision-making. Where the participant cannot make decisions, the appointment of a plan nominee or correspondence nominee safeguards their interests. For more information, refer to the Nominees Our Guideline – Appointment of Nominees, Standard Operating Procedure – Record a Nominee Request and Standard Operating Procedure – Appoint a Nominee.

The participant may need one-off or ongoing support from a third party that has consent or legal authority to act on the participant's behalf. In doing so, they may support the participant to communicate or advocate for the participant's interests. The third party may be an individual or a person from an organisation such as legal firm or advocacy group. For more information, refer to the to the Information and Your Privacy guidance on the General resources Intranet page.

9.9 Restricted Access

Information relating to participants with restricted access is to be treated with additional sensitivity. Records for restricted access participants can only be viewed by a limited number of staff with specific permissions. Restricted access can be requested by the participant or their authorised representative. Examples where this may occur are for NDIA or Partner staff who are participants, or who have family members who are participants, participants under police protection, participants where there are legal orders in place, or the participant has a protected address.

For more information, refer to the Our Guideline – Your privacy and information

.

10. Planning

Plan developers take into consideration all the information gathered in pre-planning, including risks and safeguards and build the plan to meet the needs of the participant. Consideration is given to plan duration, plan management type and inclusion of supports specific to the participant's needs.

10.1 General planning principles that safeguard the participant's interests

10.1.1 Reasonable and necessary support

Appropriate reasonable and necessary funded supports, as defined by Section 34 of the NDIS Act, are identified and included in the participant's plan. These supports are in the budget areas of Core, Capacity Building and Capital.

In developing the plan, NDIA Staff and Partners must consider whether any funded supports should **not** be provided or funded under the NDIS. A support will **not** be funded under the NDIS if it is likely to cause harm to the participant or pose a risk to others.

For more information, refer to the Our Guideline – Reasonable and Necessary Supports.

10.1.2 Planning guidance for specialist areas

The Planning intranet page contains practice guidance for participants with certain disabilities, in specific cohorts or with specialist needs and should regularly be referred to by plan developers. For example, there is specific guidance for participants with motor neurone disease to have supports in place that respond to rapidly declining function as a safeguard for the participant.

10.1.3 Stated Support

In some circumstances, supports may be included in the plan as a Stated Support. This ensures the funds are used for a vital service and cannot be used flexibly for an alternate support. An example of a Stated Support is specialist support coordination.

10.2 Core supports in the plan

Core supports assist the participant to manage aspects of daily living including self-care, accessing the community, consumable items such as daily adaptive equipment and transport. Using all available information, the appropriate level of funds are included in the plan to ensure needs are met and the participant is safeguarded from risks.

10.2.1 Core flexibility

Developing the plan with core support flexibility across the budget areas allows the participant varying levels of control over how they use their support and respond to their changing needs. The flexibility of this support helps reduce the likelihood of risks that may come up during the plan duration. For more information on the inclusion of and limitations to flexibility, refer to the Standard Operating Procedure – Complete the Determine Funded Supports task.

10.2.2 Low Cost Assistive Technology (AT)

For more information on Assistive Technology (AT) see section 10.4 Capital supports.

Low Cost AT is less than $1,500 in value and is generally also low risk. Where needed, these funds are included in the **Core - Consumables** budget, to enable the participant to purchase low cost items such as a walking stick or basic shower chair. These funds can also be used for minor repairs to AT (for example to fix a puncture). Funding is also included in the **Capacity Building – Improved Daily Living** to assist the participant in deciding which AT to purchase. This provides the participant with immediate access and flexibility to purchase AT, without the risks associated with waiting for an assessment or approval for purchase.

10.3 Capacity Building supports

Capacity building supports are linked to the goals and aspirations of the participant. When determining the funded supports in the System, funding is allocated to the specific areas of support needed by the participant. This enables the tailoring of support specific to the needs of the participant in their daily life.

The inclusion of funded supports in the plan to build capacity for independence or build skills in an identified area can be in response to a risk and therefore a safeguard.

10.3.1 Support Coordination

Plan developers consider the level of support the participant will require to build their capacity to connect with supports and services, including informal and mainstream supports. Support coordination ensures the participant is supported to understand their plan and how to:

- implement funded supports
- build capacity
- strengthen their ability to achieve their goals.

In situations where multiple mainstream interfaces are involved and/or a high level of risk, specialist support coordination may be included in the plan. This is where an allied health professional coordinates and manages the supports with the participant.

For more information on support coordination, refer to the Standard Operating Procedure – Include Support Coordination in a Plan.

10.3.2 Psychosocial Recovery Coach

Psychosocial recovery coach (recovery coach) support is available to participants whose primary disability is psychosocial disability. A recovery coach is a qualified mental health worker and through their own experiences and training, understands mental health and its impacts. They can support the participant to build confidence and motivation to achieve their goals and use their supports to live a fulfilling life. A recovery coach will also support the participant to understand how the NDIS operates within a broader ecosystem of supports including mainstream and community supports.

For further information refer to the Practice Guide – Psychosocial Disability and the Standard Operating Procedure – Include Psychosocial Recovery Coach Support in a Plan.

10.3.3 Specialist Behaviour Support

Some participants may need positive behaviour support to address behaviours of concern that represent a risk to themselves or to others. These supports are recommended to:

- support the participant's safety and wellbeing
- promote options for increasing the participant's capacity and community and mainstream connections to achieve plan goals
- provide long term sustainability of the participant's plan and informal support systems.

The reasonable and necessary inclusion of specialist behaviour support in the plan is to identify and reduce behaviours of concern, improve the participant's quality of life, uphold their dignity and safeguard their rights. As a further safeguard for the participant, positive behaviour support must be provided in accordance with the NDIS Quality and Safeguards Commission's requirements. This means providers of this support must be registered with the Commission and ensures the regulation of restrictive practices.

For more information refer to the Practice Guide – Positive Behaviour Support and Behaviours of Concern.

10.4 Capital supports

Capital supports include AT, repairs and maintenance to assistive technology, vehicle modifications and home modifications (HM). The following AT processes ensure the participant's interests and risks to the participant are considered, and minimise delay in vital equipment needs.

10.4.1 Higher Cost AT and HM

Higher cost AT, including more complex AT, is usually funded in the **Assistive Technology – Capital budget**. There is a higher risk of injury, hospitalisation or even death if appropriate assessment, setup or construction is not undertaken. This type of AT support may include vehicle modifications. HM are in the **Home Modifications – Capital budget**, and can have similar risks along with the complexity of ensuring the modification is compliant with local authority requirements.

Specialised and Complex AT require an assessment and supporting evidence from a qualified AT assessor to identify, trial and specify AT solutions. Assessments will consider options such as the participant's environment, skill building (both in doing activities and/or using AT), and the ongoing support (including specialised set up and training) required.

Home modifications will require assessment usually by an occupational therapist. In more complex cases, a building professional is also involved to determine the feasibility of the solution and assist in identifying building risks (for example asbestos or structural risk). For more information refer to the Standard Operating Procedure – Include Home Modification Supports in Plans.

10.4.2 Replacement AT

Replacement AT involves a streamlined process to avoid delays and provide a like-for-like replacement of equipment, following specific criteria and ensuring no unreasonable risks to the participant are identified.

10.4.3 Rental/Hire of AT

It may be reasonable and necessary to include funding for rental of AT for a specified period of time whilst the participant awaits supply of their customised AT equipment. This will ensure the participant's safety is not at risk, where AT supply may be delayed.

10.4.4 AT during the course of the plan period

During planning, supports are included based on the information available at that time.

If an assessment recommending AT is received during the course of the plan period, the delegate must determine if there are any risks to the participant in delaying access to the AT supports and if the recommended AT is reasonable and necessary. A delegate must consider if the AT needs to be funded immediately to mitigate risks, or can be funded at the next scheduled plan review. An unscheduled review may be initiated based on the participant's request or as an Agency initiated review.

Refer to Our Guidelines - Assistive technology on the NDIS website and Assistive Technology guidance on the Planning resources Intranet page.

10.5 Plan management

Plan management is how the participant or their representative manages the support budgets of the plan. Plan management may be self-managed, plan managed, Agency managed or a combination. Throughout the pre-planning, planning and implementation stages of the participant pathway, the participant is made aware of the benefits and responsibilities of each plan management option.

The risk assessment tool assesses the participant's capacity to undertake self-management or plan management, if they have requested this, and what supports they may need to help them manage their plan. This tool is used in pre-panning, see section 9.6 Risk assessment and plan duration. During the planning process, the Determine Plan Management task is completed in the System to divide funds as Self, Agency or Plan managed at the individual budget level. For more information refer to the Standard Operating Procedure – Complete the Determine Plan Management task.

A request by a participant to manage their funding should be considered positively unless there is evidence a financial or personal risk exists. Specific plan management options may be preferable due to individual circumstances which may include State Trustee/Public Guardian involvement or NDIA arrangements. For further information on plan management and behaviour supports refer to the Practice Guide – Positive Behaviour Supports and Behaviours of Concern.

Where the participant needs support to self-manage, reasonable and necessary supports to build the participant's capacity to self-manage are considered. This may include support to assist the participant, their plan nominee or child representative to learn budgeting, book keeping, skill building by a plan manager or support coordinator. Plan management discussions, requests and decisions are recorded in the System.

If the funds will be self-managed by the plan nominee or child representative, risks to the participant of them managing these funds must be assessed. The assessment of risk of harm is always related to risks to the participant, regardless of who will be managing the funding.

11. Plan Implementation and Monitoring

11.1 Assistance for the participant to implement their plan

The participant is supported to implement their plan by either a PiTC or support coordinator, based on their streaming. For participants with psychosocial disability a recovery coach may support them with implementation of their plan. Specific information regarding a risk or safeguard may be communicated to the PiTC through an interaction in the System and/or Plan Alignment Meeting. The partner staff member completes the implementation section in the System. For more information, refer to the Standard Operating Procedure – Complete the Determine Plan Management task.

If the participant has a support coordinator or recovery coach to support them to implement their plan, specific information regarding risks and safeguard measures can be communicated through the Request for Service form completed in the System. For more information refer to the Standard Operating Procedure – Request for Service – Make a request. Along with the information contained in the plan, safeguard strategies and additional information specifically for the support coordinator or recovery coach to follow-up may be recorded on the form.

Plan implementation includes empowering the participant to negotiate their supports and create service agreements with providers of support. Specific requirements to safeguard the participant may be communicated to providers of support at this point.

In the process of implementing the plan, further risks and safeguards may be identified and managed. If necessary an unscheduled plan review request (PRR) or internal review of a decision may occur to address the interests of the participant. Refer to Practice Guide – Unscheduled Plan Reviews and Our Guideline – Reviewing our decisions (external).

11.1.1 Communication preferences

The participant's communication preferences are considered and recorded in the System. Their plan is communicated in a format that assists them to understand their supports. For more information, refer to the Standard Operating Procedure – Assist the Participant with their Preferred Method of Communication.

11.1.2 My NDIS Contact

The participant's plan and the participant portal state the name and phone number of their My NDIS Contact, allowing them to make contact with the appropriate staff member.

Regular contact with the participant can be organised as part of the safeguard approach. Contact may be made by the PiTC, support coordinator or recovery coach who can also make regular monitoring arrangements.

11.1.3 Monitoring

Monitoring the participant's plan may occur by NDIA staff including when contact is made to resolve enquiries or implement quotes. The utilisation of supports in the plan can be monitored through the reporting platform – NDIS Panda Live.

Monitoring can include reviewing the plan budget, payment requests, periodic payments and risks that may escalate requiring a plan review.

For more information refer to PANDA Live and the Standard Operating Procedure - Monitor the Plan Budget and Standard Operating Procedure - Payment Requests.

12. Plan reviews

The plan review process includes completing the pre-planning, planning and plan management tasks. The participant's circumstances may have changed and a review is an opportunity to identify new risks, assess previous risks and implement new safeguards. The following is reviewed and adjusted:

- the participant still meets the requirements of their current stream - general, supported, intensive or super intensive to ensure support to engage with the NDIS is appropriate
- current circumstances, any change to environmental context, mainstream supports and in particular informal supports
- progress towards goals and what funded supports may no longer be required where capacity has been developed, for example support coordination. New goals and supports that may now be required, for example progressing to volunteer work or gaining employment
- plan length and plan management requirements
- when determining reasonable and necessary supports for a review plan, consideration is given to the previous plan's value and the utilisation of any funded supports in comparison with the new plan's generated funded supports.

For further information refer to the:

- Standard Operating Procedure – Support Tool to Determine the Scheduled Plan Review Approach
- Standard Operating Procedure – Complete a Plan Review (Full)
- Standard Operating Procedure – Complete a Plan Review (Light Touch)
- Standard Operating Procedure – Complete a Scheduled Plan Review (Renewal)
- Practice Guide – Scheduled Plan Reviews.

12.1 Unscheduled Plan Review

A participant requested plan review may be undertaken as a result of a change to a participant's circumstances. For example, the participant's functional capacity has changed, which has resulted in a change to their support needs.

An Agency initiated plan review may be required during the course of the participant's current plan period to meet the participant's needs. For example, information indicating a risk to the participant and they are unable to request the review themselves, or they have no representative to do so. An Agency initiated review may also occur where information is

received recommending AT and the participant would be placed at risk if this was not considered until the next scheduled review.

For more information refer to the Practice Guide – Unscheduled Plan Reviews.

13. Supporting material

- Participant Critical Incident Framework
  - Form – Participant critical incident notification form
  - Standard Operating Procedure – Initial Response to a Participant Critical Incident Notification
  - Standard Operating Procedure – Internal notification of a participant critical incident
  - Standard Operating Procedure – Undertaking Follow Up Action for a Participant Critical Incident
  - Standard Operating Procedure – Closure and Reporting of a Participant Critical Incident
- Our Guideline – Your privacy and information
- Overview of the NDIS Our Guideline – Quality and Safeguards
- Overview of the NDIS Our Guideline– Section 4.4.4 Principles relating to the participation of people with a disability
- Access to NDIS Our Guideline – Section 4.11 Prioritising prospective participants with urgent circumstances
- Planning Our Guideline – Performing a support needs assessment – Section 8.4 Assessing risks and safeguards
- Our Guideline – Younger People in Residential Aged Care
- Practice Guide – Children at Risk of Requiring Accommodation Outside the Family Home
- Our Guideline – Justice system (external)
- Practice Guide – Psychosocial Disability

14. Process owner and approver

General Manager, Participant Experience Design.

15. Feedback

If you have any feedback about this Practice Guide please complete our Feedback form.

16. Version change control

Version No	Amended by	Brief Description of Change	Status	Date
3.0	CS0074	Class 1 approval. Revised wording to section 10.5 - Plan management, to emphasise that requests from participants to self-manage should be considered positively unless there is evidence that a financial or personal risk exists.	APPROVED	2020-07-06
4.0	CS0074	Class 1 Approval Included links for participant check in resources. Included information on the new psychosocial recovery coach support for participants with psychosocial disability.	APPROVED	2020-07-20
5.0	CS0074	Class 1 Approval Removed reference to SIL being a stated support	APPROVED	2020-07-29

6.0	JS0082	Class 1 Approval Sentence on PED KPIs included in Purpose to encourage compliance with KPIs relevant to pre-planning. General updates to wording and formatting for consistency and readability.	DRAFT	2020-12-22
7.0	NAN927	Class 1 Approval Updated links to assistive technology resources.	APPROVED	2021-01-13
8.0	CS0074	Class 1 approval received on 2021-01-08 to update links to nominee resources	APPROVED	2021-01-14

The National Disability Insurance Scheme

The World Health Organisation Disability Assessment Schedule (WHODAS) 2.0

April 2017

Overview of the WHODAS

- a generic assessment instrument developed by the World Health Organisation
- standardised method of measuring health, level of functioning, and disability in adult populations
- covers six domains of functioning: cognition, mobility, self-care, getting along, life activities, and participation
- there are several versions of the WHODAS 2.0 based on the number of items and administration method (for example 36-item self-administered)
- the 12-item (interview-administered) version will be covered today and used for data collection.

WHODAS 12-item version

Core questions

Rating scale for level of difficulty experienced:

1 = None 2 = Mild 3 = Moderate 4 = Severe 5 = Extreme (or cannot do)

Please indicate the level of difficulty you had in the past 30 days, in the following areas:

1	Standing for long periods such as 30 minutes?	7	Walking a long distance such as kilometre (or equivalent)?
2	Taking care of your household responsibilities?	8	Washing your whole body?
3	Learning a new task, for example, learning how to get to a new place?	9	Getting dressed?
4	Joining community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	10	Dealing with people you do not know?
5	How much have you been emotionally affected by your health problems?	11	Maintaining a friendship?
6	Concentrating on doing something for 10 minutes?	12	Your day-to-day work/school?

WHODAS 12-item version (cont.)

Additional questions

Please record the number of days for each of the questions below		
13	Overall, in the past 30 days, how many days were the difficulties above present?	Num. of days
14	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	Num. of days
15	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	Num. of days

Frames of reference

Frames of references for answering questions*

Respondents should answer questions with the following frames of reference:

- frame 1 – degree of difficulty
- frame 2 – due to health conditions
- frame 3 – in the past 30 days
- frame 4 – averaging good and bad days
- frame 5 – as the respondent usually does the activity
- frame 6 – items not experiences in the past 30 days are not rated.

*see pages 38 to 40 in the manual

Frames of reference (cont.)

Frames of reference 1 – degree of difficult

Respondents are asked questions about the degree of difficulty that they experience in doing different activities. For WHODAS 2.0, having difficulty means:

- increased effort
- discomfort of pain
- slowness
- changes in the way the person does the activity.

Frames of reference (cont.)

Frames of reference 2 – due to health conditions

- respondents are asked to answer about difficulties due to their **primary disability**, rather than other causes.

Frames of reference 3 – in the past 30 days

- the timeframe for WHODAS 2.0 is 30 days, as recall abilities are most accurate for the period of one month.

Frames of reference 4 – averaging good and bad days

- some respondents will experience variability in the degree of difficulty that they experience over a 30 day period.
- in these cases, respondents should be asked to give a rating that averages good and bad days.

Frames of reference (cont.)

Frames of reference 5 – as the respondent usually does the activity

- respondents should rate the difficulty experienced by taking into consideration how they usually do the activity. For example, if assistive devices are usually available, respondents should keep this in mind.
- support from a person should not be taken into account when responding.

Frames of reference 6 – items rated as not applicable

- the instrument seeks to determine the amount of difficulty encountered in activities that a person actually does, rather than activities that person would like to do or can do, but does not actually do.
- for example, considering item D2.5 “how much difficulty did you have in walking a long distance, such as one kilometre?”
  - If a participant cannot walk one kilometre because of his/her impairment, the item would be rated a “5” (for example “extreme or cannot do”)
  - However, if a participant has not tried to walk one kilometre simply because he/she drives everywhere, then the item would be coded “N/A (not applicable)

Clarifying unclear responses

Rules for clarification and probing

- if a question is misunderstood or not fully heard > repeat the question
- when a specific part of the question is queried > repeat only that portion
- if repeating the question is not helpful > use the explanations from the question-by-question specifications.
- if still not sure > instruct respondent to answer the question using their own definition or interpretation of the word, phrase or concept.
- when asked to repeat one or more response options > repeat all response options.
- use only the question text or neutral probes to avoid introducing bias > for example “Can you tell me what you mean by that?” “Can you be more specific?”

Clarifying unclear responses (cont.)

Common probing situations

<u>"I Don't know " (DK)</u>

- general rule is to repeat the question. If this is unsuccessful, probe using the neutral probe examples for example "Could you give me your best estimate?"
- if respondents still cannot respond, record as "DK".

<u>Not applicable (N/A)</u>

- probe all responses of N/A for example "Can you tell me why this question does not apply to you?"

<u>Discrepancies</u>

- refer back to the frames of reference for example where difficulties are indicated for reasons other than the health condition.

Clarifying unclear responses (cont.)

Examples of suitable neutral probes

- Can you tell me what you mean by that?
- Can you tell me more about that?
- What do you think?
- Which would be closer – slight or moderate?
- Can you think of any others?
- What is your best estimate?
- Can you be more specific?
- Can you give me your best guess?
- Can you provide one overall rating?

Break-out activity (15 mins)

- In pairs, administer the 12-item WHODAS:
  - one person is the interviewer asking the WHODAS questions
  - the other person plays the role of respondent.
- Take a few minutes to read over the rules / strategies for clarifying unclear responses, and the specifications for your allocated question.
- Carry out the interview, clarifying and probing accordingly.
- At the end, debrief with your partner about how it went.
- Feedback to the broader group for discussion / questions.

Preamble for the WHODAS

Script for introducing the 12-item WHODAS

Hello. I'm going to ask you a set of questions that relate to everyday activities that you may perform. I would like to understand the level of difficulty you have in doing these activities, as a result of your primary or core disability.

When I ask about difficulties in doing an activity, think about: increased effort, discomfort or pain, slowness, or changes in the way you do an activity.

Also, when answering, I'd like you to think back over the past 30 days about how much difficulty you have had on average.

Finally, please consider how you usually do an activity and use this scale when responding: none, mild, moderate, severe, extreme or cannot do.

Question-by-question specifications*

Domain	Question	Specification
D2: Mobility	1. Standing for long periods (such as 30 minutes)	-
D5: Life activities	1. Taking care of your household responsibilities	This global question is intended to elicit respondents' appraisal of any difficulty they encounter in maintaining the household and in caring for family members or other people they are close to. Ask respondents to consider all types of household or family needs, including: physical needs; emotional needs; financial needs; and psychological needs. In some cultures, males may indicate that they do not have household responsibilities. In this situation, clarify that household responsibilities include; managing finances; car and home repairs; caring for the outside area of the home; picking up children from school; helping with homework; and disciplining children. Here, "household" is defined broadly. In the case of participants who do not have a stable dwelling place, there are still activities surrounding the upkeep and maintenance of their belongings. This question refers to those activities.

* Source: WHODAS 2.0 manual. See pages 48 to 54 for more detailed information.

Question-by-question specifications* (cont.)

Domain	Question	Specification
D1: Cognition	3. Learning a new task (for example, learning how to get to a new place)	If respondents ask for clarification or appear to be thinking only about learning how to get to a new place, encourage them to think of other situations in the past month where learning something new was required, such as a task at: work (for example a new procedure or assignment); school (for example a new lesson); home (for example learning a new home-repair task); or leisure (for example learning a new game or craft). Ask the respondents when rating themselves to consider how easily they acquired new information, how much assistance or repetition they needed in order to learn and how well they retained what they learned.
D6: Participation	4. Joining community activities (for example festivities, religious or other activities) in the same way as anyone else can	If necessary, clarify this question using other examples of community activities, such as attending town meetings, fairs, leisure or sporting activities in the town, neighbourhood or community. The relevant issue being asked in this question is whether respondents can participate in these activities or whether there are inhibitors to them doing so. If respondents appear confused by the phrase “in the same way anyone else can” ask them to use their judgement to: assess the extent to which average people in their community can join community activities; and consider their personal level of difficulty in joining community activities in relation to the assessment.

* Source: WHODAS 2.0 manual. See pages 48 to 54 for more detailed information.

Question-by-question specifications* (cont.)

Domain	Question	Specification
D6: Participation	5. Emotionally affected by your health problems	This question refers to the degree to which respondents have felt an emotional impact due to their health condition. Emotions may include anger, sorrow, regret, thankfulness, appreciation, or any other positive or negative emotions.
D6: Participation	6. Concentrating on doing something for 10 minutes	If clarification is requested, encourage the respondent to think about their concentration in usual circumstances, rather than when they are preoccupied by a problem or are in an unusually distracting environment. If necessary, prompt the respondent to think about their concentration while they were doing something such as work tasks, reading, writing, drawing, playing a musical instrument, assembling a piece of equipment, and so on.
D2: Mobility	7. Walking a long distance (such as a kilometre or equivalent)	Convert distances into imperial measure where necessary (for example older people may be more familiar with miles than with kilometres).

* Source: WHODAS 2.0 manual. See pages 48 to 54 for more detailed information.

Question-by-question specifications* (cont.)

Domain	Question	Specification
D3: Self-care	8. Washing your whole body	This question refers to respondents washing their entire body in whatever manner is usual for their culture. If respondents report that they have not washed their bodies in the past 30 days, ask whether this is due to a health condition (as defined under frame of reference 2)
D3: Self-care	9. Getting dressed	This questions includes all aspects of dressing the upper and lower body. Ask respondents to consider activities such as gathering clothing from storage areas (for example closet, dresser) and securing buttons, tying knots, when making the rating.
D4: Getting along	10. Dealing with people you do not know	This item refers to interactions with strangers in any situation, such as: shop-keepers, service personnel, and people from whom one is asking directions. When making the rating, ask respondents to consider both approaching such individuals and interacting successfully with them to obtain a desired outcome.

* Source: WHODAS 2.0 manual. See pages 48 to 54 for more detailed information.

Question-by-question specifications* (cont.)

Domain	Question	Specification
D4: Getting along	11. Maintaining a friendship	This item includes: staying in touch; interacting with friends in customary ways; initiating activities with friends; and participating in activities when invited. Respondents will sometimes report that they have not engaged in friendship-maintenance activities in the past 30 days. In this case, ask whether this situation is due to a health condition.
D5: Live activities	12. Your day-to-day work and/or school	This global question is intended to elicit respondents' appraisal of difficulties encountered in day-to-day work or school activities. This includes issues such as attending on time, responding to supervision, supervising others, planning and organising, meeting expectations in the workplace and any other relevant activities.

* Source: WHODAS 2.0 manual. See pages 48 to 54 for more detailed information.

Version control

Version No	Amended by	Brief description of change	Status	Date
2.0	NAN927	Class 1 Approval Annual Review consulted with PBQ096 from Insurance Support Branch.	APPROVED	2020-03-16
3.0	NAN927	Class 1 Approval Accessibility updates	APPROVED	2020-03-18

ndis

Frontline Essentials: Making Connections, Applying and Access

Session outline: Day 1

Topic 1: Pathway and Roles

Topic 2: Early Childhood Approach

Topic 3: Local Area Coordination Approach

Topic 4: Community Connections Case

Topic 5: My profile

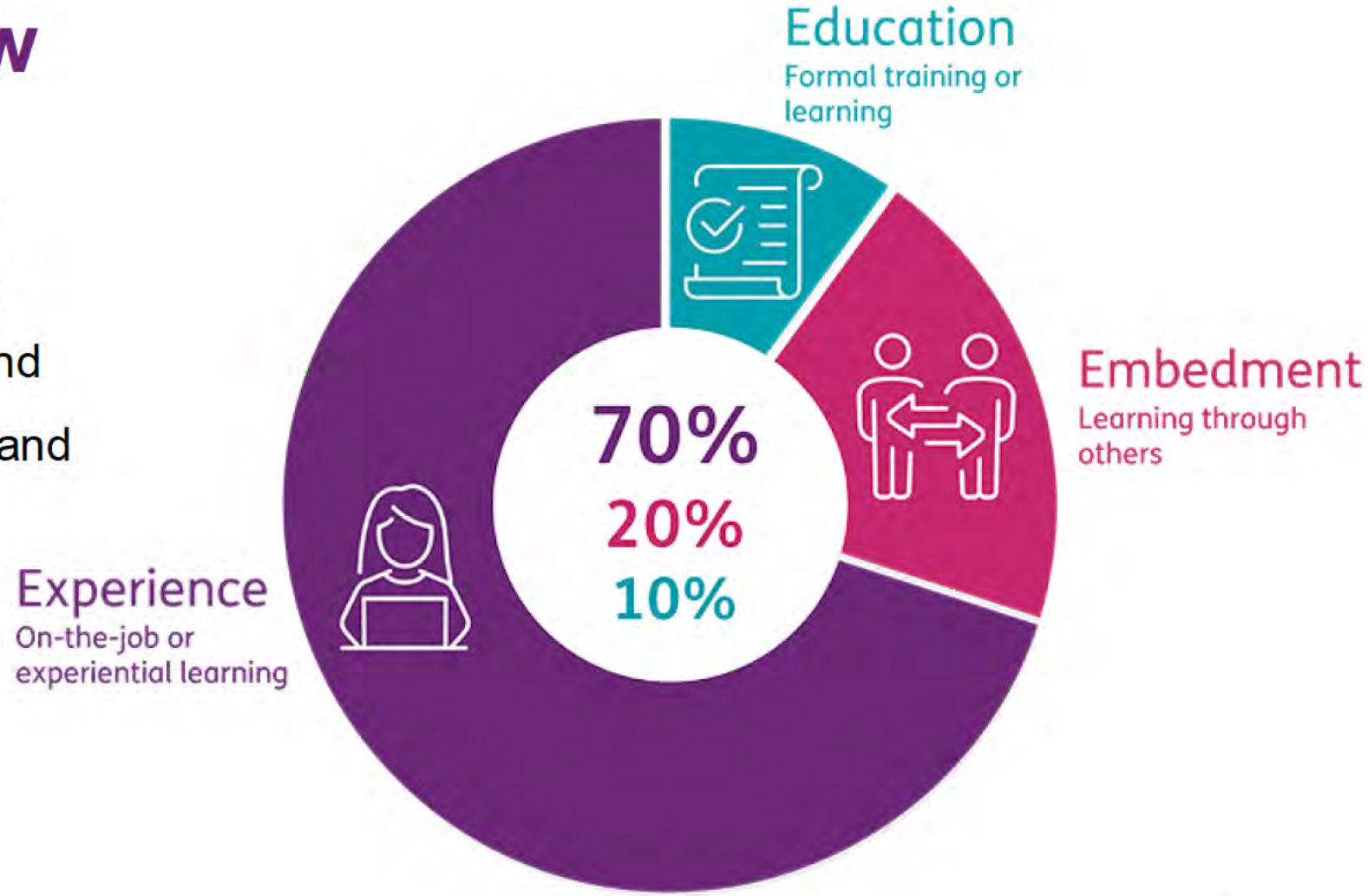
Learning outcomes: Day 1

By the end of this session, you will be able to:

- Identify pathways and roles
- Understand and apply the Early Childhood Approach
- Understand and apply the Local Area Approach
- Understand community connections cases
- Create a My Profile and understand parts of the profile

Program overview

The program includes facilitated sessions, workshops, on-the-job training, self-directed learning, and check-ins with your team leader and facilitator.



Topic 3: Tools used to gather information

Developmental concerns or developmental delay

For children younger than 6, an early childhood partner gathers a range of information to determine if the child can be described as having developmental concerns or developmental delay. Some of the ways they may do this is through:

- Talking to families
- Reviewing information from professionals who know the child well
- Making observations of the child in their natural setting
- Completing an ecomap
- Implementing the Ages and stages questionnaire
- Implementing the PEDI-CAT
- Creating a person account plus a child representative account in PACE.

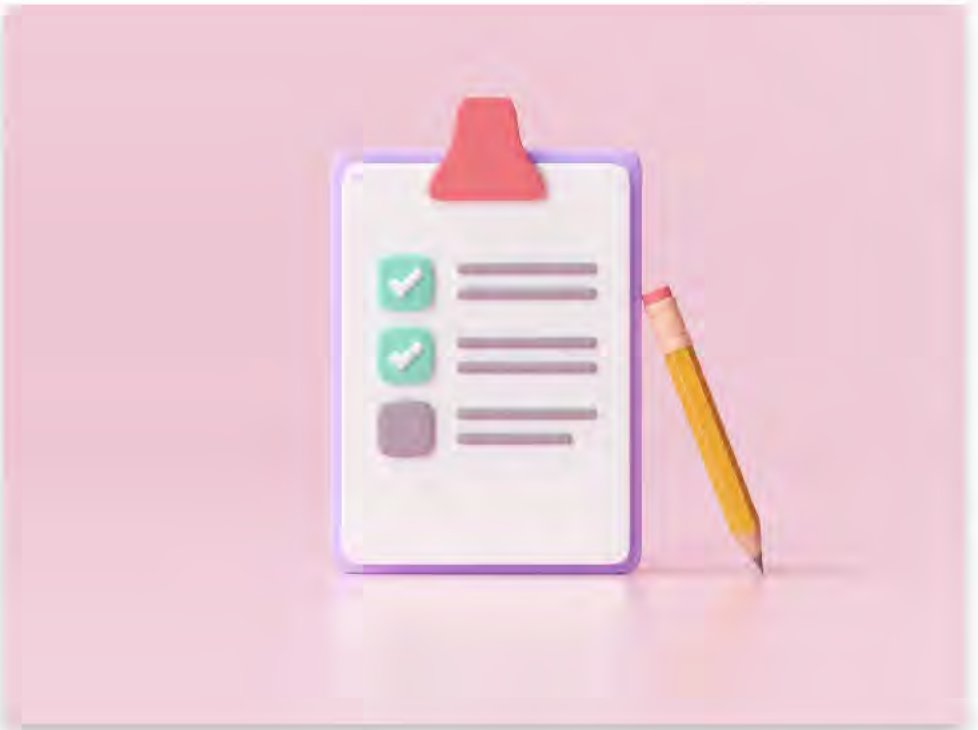
The ASQ for an early childhood partner

The Ages and Stages Questionnaire (ASQ) is a developmental screening tool that Early childhood partners use to gather information about a child's development.

- It involves asking the child representative questions around the child's daily life, including development.
- A score is generated that is used to interpret if the child shows developmental concerns or developmental delay.
- This information provides supporting evidence for the applying to the NDIS, or for if early connections/ supports alone is the best pathway.

The PEDICAT

- We always use the PEDICAT assessment with children younger than 6
- Sometimes, we use PEDICAT for children aged 7-16 if there isn't another tool available



Topic 2: Functional capacity assessment

Functional capacity assessment

Functional capacity assessments are a form of evidence.

We use them to:

- help us identify the level of support and funding they will need in their plan
- understand how they manage everyday activities
- assist us in making decisions.

Types of functional capacity assessments

Depending on a person's developmental delay or disability, a specific functional capacity assessment may be required. It's important to check knowledge article in PACE, as some need to be completed by a health care professional.

General (unspecified)

- Life skills profile (LSP -16)
- WHODAS
- PEDICAT

Hearing Loss

Vision Loss

Spinal Injury

Traumatic Brain Injury

Intellectual Disability

Cerebral Palsy

Individual Activity: Who can complete what assessment?

Review resources and note down whether it is the Agency or a Health professional that can complete the assessments.

There is space in your learner workbook to note down your answers.

Individual Activity: Debrief

	WHODAS	PEDI-CAT	Life skills profile	Hearing loss	Vision loss	Spinal injury	Traumatic brain injury	Intellectual disability	Cerebral Palsy
Allied or health professional	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
NDIA staff or partner	Yes	Yes	No	Yes	Yes	No	No	No	Yes

Functional capacity assessments

A **manual** assessment refers to any previously completed functional capacity assessments.

A **new** assessment refers to you completing a new PEDI-CAT or WHODAS assessment in PACE

When collecting functional capacity assessment information, the score of an external assessment needs to be provided by:

- The person
- Their nominee
- Their child representative
- Their treating health professional

Different assessment tools may have requirements over who can administer them, such as qualified health professionals.

Completing a functional capacity assessment

- Check for exceptions
- Log an activity in PACE
- Complete a new assessment

Internal disability specific severity tools

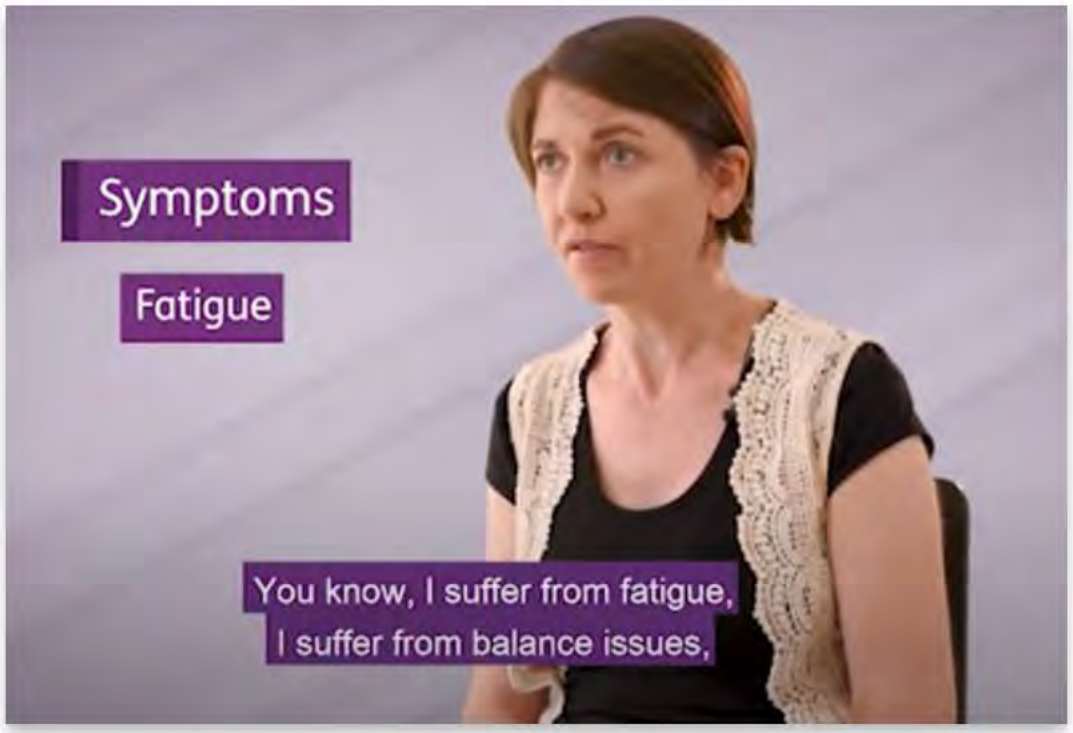
The internal disability specific severity tools that can be completed by Agency staff and partners include:

- Gross Motor Function Classification Scale (GMFCS) for **Cerebral Palsy**
- Modified Rankin Scale (mRS) for **Stroke**
- Disease Steps for **Multiple Sclerosis**
- **Hearing** tool
- **Vision** tool

Locating resources

Tools	Update Severity Indicator - Cerebral Palsy	
Tools	Update Severity Indicator - Hearing	
Tools	Update Severity Indicator - Multiple Sclerosis	
Tools	Update Severity Indicator - Stroke	
Tools	Vision Impairment Tool	

Example MS



1. What symptoms do you have due to your MS?

Details	

2. Do your symptoms have any effect on your activity level or lifestyle?

Details	

3. If so, what is that level of effect on your lifestyle for example, minor, moderate, severe?

Details	

4. After an attack, do you return to normal?

Details	

5. Does your MS interfere with your walking?

Details	

6. Do you use a mobility aid?

Details	

7. If so, what type?

Details	

Group Activity 6: Using severity tools

1. Use the Intranet to locate the Update Severity Indicator – Multiple Sclerosis tool

   Home > Service Delivery > Pre-Planning > Topic: preparing for Planning > Update Severity Indicator - Multiple Sclerosis

2. Watch Sonia's video: Andrew and Sonia - Lived Experience (external)

   Home>Service Delivery>Disability Navigator>Multiple Sclerosis

3. In your groups, complete the Multiple Sclerosis severity tool for Sonia

Assessment not specific to a disability type

If there are no relevant disability specific assessments or internal disability specific tools then we would use an assessment that is not specific to a disability type.

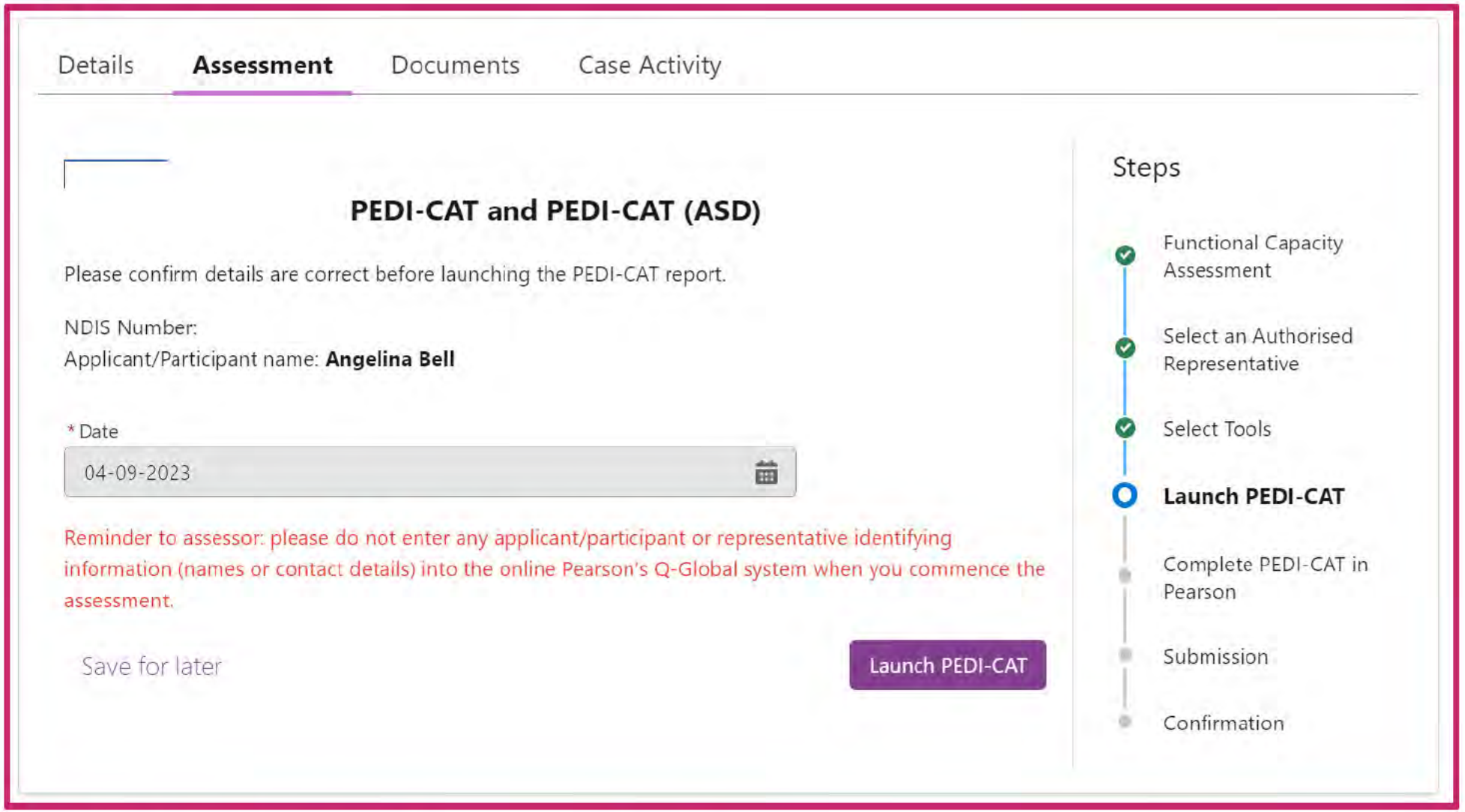
Assessments not specific to disability type:

- Can be completed by NDIA staff and partners
- Include PEDICAT (0-16) and WHODAS 2.0 (+17).

WHODAS demonstration

We are now going to go through a WHODAS demonstration. During the demonstration, please take notes as you will complete a similar activity during your self-directed learning.

PEDI-CAT



Topic 3: The Access Request Case in PACE

Version Control

Version	Amended by	Description	Status	Date
V2.0	RWP064	Links updated, Edits	Draft	04/03/24
V2.1	SSN695	Links and content updated	Draft	09/05/24
V2.2	SJT409	Links and content updated	Draft	01/08/2024
V3.0	AIA372	Legislation updates	Final	29/10/2024

Frontline Essentials

Making Connections, Applying and Access - Program Guide

The contents of this document are OFFICIAL.

Program guide to support the training for the Making Connections, Applying and Access facilitated modules. This program guide provides additional information to the PowerPoint for facilitators.

Table of Contents

- next steps.

It is recommended that the following tabs should also be completed (but is not mandated):

- my NDIS Contact
- Ecomap
- Profile

3. What kind of information would be recorded about Bri in a community connections plan?

Put what you think in the chat, or raise your hand if you would like to share your thoughts.

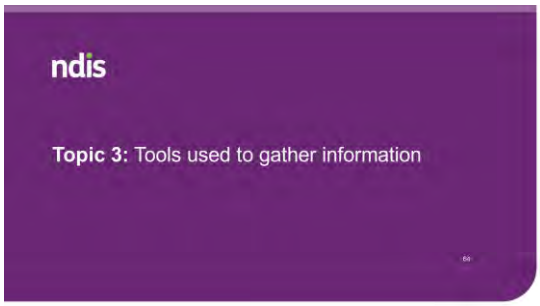
Facilitator notes: field responses for about 1-3 minutes

A community connections plan records information about the person, their goals, how they want to work towards their goals, next steps and what community and mainstream/other government supports may help.

Time: 10 minutes

Topic 3: Tools used to gather information

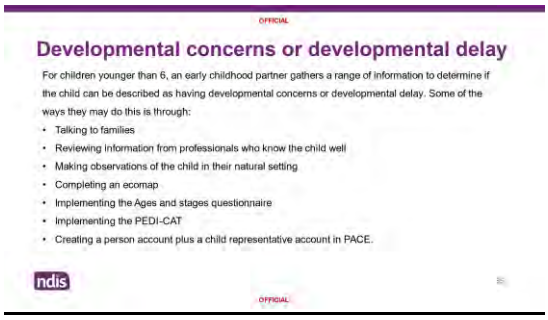
Display Slide 64



Topic 3: Tools Used to Gather Information

Developmental concerns or developmental delay

Display Slide 65



Facilitator note: Advise learners to take note of this slide as this information can be used to assist them in an upcoming discussion.

State: Community connections plans are generally not generated for children younger than 6.

For children **younger than 6**, an early childhood partner gathers a range of information to determine if the child can be described as having developmental concerns or developmental delay. If the early childhood partner determines that a child is best described as having developmental concerns or if they are not yet sure if the description of developmental delay applies, early supports are offered to their family.

In areas that have early childhood partners, some of the ways they may gather information to determine if the child can be described as having developmental concerns or developmental delay is through:

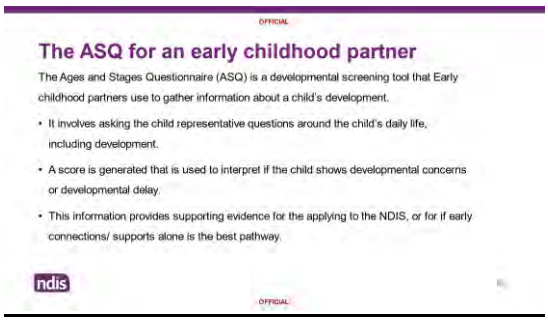
- Talking to families
- Reviewing information from professionals who know the child well
- Making observations of the child in their natural setting
- Completing an ecomap
- Implementing the Ages and stages questionnaire
- Implementing the PEDI-CAT
- Creating a person account plus a child representative account in PACE.

Whilst a child who very clearly fits the description of developmental delay is best supported by applying for the NDIS, early supports is an appropriate option if their presentation is unclear.

Time: 3 minutes

The ASQ for an early childhood partner

Display Slide 66



State: The ASQ is a developmental screening tool that is used to gather information about a child's development. Early childhood partners use it to screen for delays in development. It is used, together with other information to help determine if a child has developmental delay or developmental concerns.

If you are an early childhood partner, spend some more time exploring these tools when you have time.

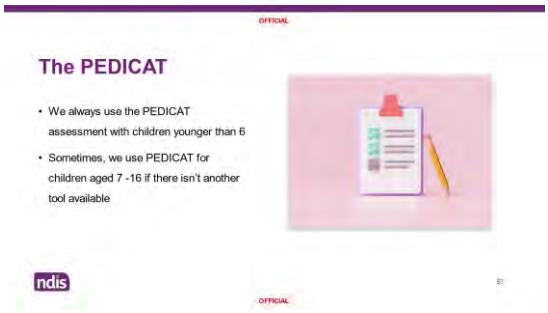
You can use the article to understand and identify the steps to complete the ASQ. Completing the ASQ involves asking the child representative a series of questions about how their child functionality, their development, and their daily life. A score is generated that is used to interpret if the child shows developmental concerns or developmental delay, along with other information. This information provides supporting evidence for the applying to the NDIS, or for if early connections/ supports alone is the best pathway.

You can search for the related knowledge articles using keywords in the training environment.

Time: 3 minutes

The PEDICAT

Display Slide 67



State: A PEDI-CAT assessment helps us understand a child's ability to complete tasks in their daily life.

We use the PEDI-CAT assessment with children younger than 6. Sometimes, we use PEDI-CAT for children aged 7-16 if there isn't another tool available.

The PEDI-CAT is a functional capacity assessment tool. It is used to measure a child's functional capacity when compared to other children of a similar age across four domains: daily activities, mobility, social/cognitive and responsibility.

There are two applications of the PEDI-CAT:

- To help determine functional capacity. In addition to the results of the ASQ and other information gathered, the PEDI-CAT can be used to help identify delays in development. Early childhood partners can use the PEDI-CAT when determining a child's support needs.
- To measure changes in functional capacity over time. The PEDI-CAT can be used to help measure changes in functional capacity over time in response to early childhood intervention. It is completed by the early childhood partner at both the commencement and the completion of early supports.

Time: 2 minutes

State: Some assessments you can complete, but it is important to check as many require a health professional.

When we're deciding if a participant is eligible for the NDIS, we look at:

- how old their evidence is
- who provided their evidence.

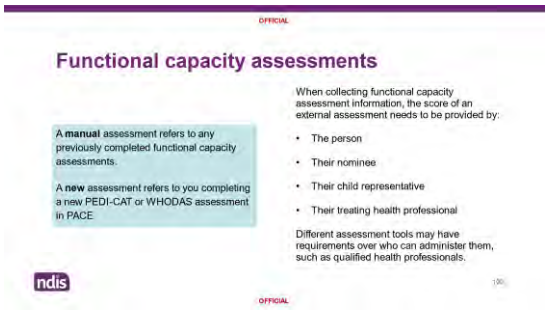
We weigh evidence based on what we consider 'best practice', or highest quality. We generally prefer evidence that comes from a treating professional who:

- is the most appropriately qualified person to provide evidence of the person's primary disability
- has treated the person for a significant period of time (at least six months)
- is registered to practise in Australia or New Zealand
- provides disability evidence (such as a medical report) that is original, genuine and specific to the person.

Time: 6 minutes

Functional capacity assessments

Display Slide 110



State: A manual assessment refers to any previously completed functional capacity assessments. When collecting functional capacity assessment information, the score of an **external assessment** needs to be provided by:

- The person
- Their nominee
- Their child representative
- Their treating health professional.

For example, a person might give you a report from their doctor and you will enter the scores from the report in PACE.

A new assessment refers to you completing a new PEDI-CAT or WHODAS assessment in PACE.

Time: 2 minutes

Completing a functional capacity assessment

Display Slide 111

State: Before completing the assessment, check for any exceptions, including:

- if the person does not want to complete assessment
- if the person has a priority situation
- if there are any identified risks

- if they have reapplied within the last 6 months.

When contacting an applicant, participant, their provider, or authorised representative, you must:

- check their preferred communication method and authorisations
- log an activity.
- Read the related knowledge articles.

Complete a new assessment

You need to make the person feel comfortable when communicating. When you are talking to them face to face or over the phone, make sure you:

- prepare for the conversation
- understand the person-centred approach
- understand the question you are asking
- tailor wording from assessment questions
- build rapport
- actively listen
- manage expectations with the individual that this does not mean they will get a funded NDIS plan.

For more information, go to the Conversation Style Guide.

To begin a functional capacity assessment, you must create a new **Functional Capacity Assessment** case within PACE. You can follow the steps in the knowledge article relating to creating new functional capacity assessments to do this.

Time: 3 minutes

Internal disability specific severity tools

Display Slide 112

State: The internal disability specific severity tools that can be completed by Agency staff and partners include:

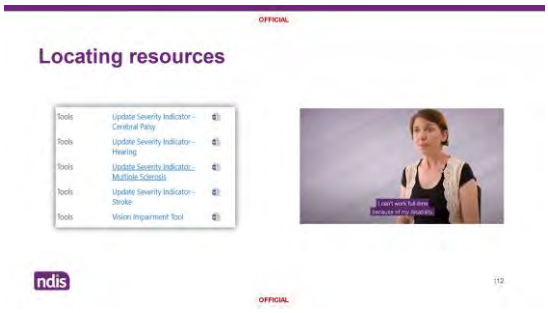
- Gross Motor Function Classification Scale (GMFCS) for Cerebral Palsy
- Modified Rankin Scale (MRS) for Stroke
- Disease Steps for Multiple Sclerosis
- Hearing tool
- Vision tool

The internal tools can be found on the intranet and the score updated in the Functional capacity case.

Time: 2 minutes

Locating resources

Display Slide 113



Facilitator Demonstration

State: I'm going to show you where we find these tools.

Show learners where the severity tools are located on the intranet.

Home>Service Delivery>Pre-Planning>Topic: Your Plan>Update Severity Indicator Tools. Docx (769KB).

Pre-Planning (ndia.gov.au - external)

Time: 5 minutes

Example MS

Display Slide 114

State: Let's have a look at the disease steps classification scale and what this may look like with a person who lives with MS.

The disease steps classification scale assesses the level of impact multiple sclerosis has on the participant's daily activities. We use this where they have identified multiple sclerosis as their primary disability.

To do a multiple sclerosis assessment, use one of these sources in preference order:

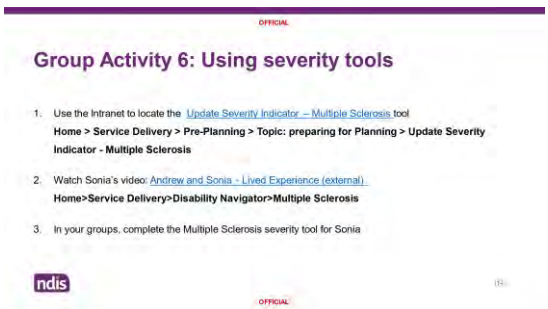
- **Disease steps**: for all ages – provided by a medical professional or equivalent.
- **Multiple sclerosis severity tool:** for all ages - Patient Determined Disease Steps (PDDS), available on the NDIS intranet. Provided by a medical professional or equivalent or completed internally.
- **Expanded Disability Status Scale (EDSS)**: for all ages – provided by a medical professional or equivalent.

Note: Evidence from a treating health professional should be from a neurologist or a disease steps trained nurse examiner. It is really important to note who has completed the reports, as certain reports are required to be completed by specific professionals. For example, Autism Spectrum Disorder requires a diagnosis by a Clinical psychologist, paediatrician, or a psychiatrist stating ASD Criteria has been met. A diagnostic assessment from a general psychologist or an occupational therapist would not be accepted.

Time: 5 minutes

Group Activity 6: Using severity tools

Display Slide 115



State: We are going to complete an activity using one of the tools. The severity tool helps to understand the support needs and can help us see how the disability impacts their daily life.

Let's look for that tool together in the service delivery tab.

Facilitator Note: Demonstrate finding the correct tool. Home>Service Delivery>Pre-planning>Topic: Your Plan>Update Severity Indicator – Multiple Sclerosis Tool.docx (763KB)

State: We're going to watch a video about Sonia, and then in your groups, you will determine what functional capacity she is by using the Multiple Sclerosis Severity Tool. Sonia's video can be located under multiple sclerosis on the disability navigator.

Facilitator note: Demonstrate finding Sonia's video. Home>Service Delivery>Disability Navigator>Multiple Sclerosis>Andrew and Sonia lived experience.

Break learners into three groups to complete the Multiple Sclerosis tool.

Debrief: Display the Multiple Sclerosis Tool on the screen and review the answers together as a group.

Facilitator note: Possible answers below

1. What symptoms do you have due to your MS?
   Loss of function in hands and legs, fatigue, balance issues, poor heat regulation, poor self-management of bladder/bowel.

2. Do your symptoms have any effect on your activity level or lifestyle?
   Yes – has never been able to work full-time due to MS, and took a long time to find paid employment (12-13 years after diagnosis). Needs a home with climate control (a/c), no steps and which has good accessibility including a toilet close to bedroom – not always available in rentals, and due to income limitations has always rented.

3. If so, what is that level of effect on your lifestyle for example, minor, moderate, severe?
   Moderate to severe

4. After an attack, do you return to normal?
   Currently stable – no active decline happening

5. Does your MS interfere with your walking?
   Yes – walks over very short distances, motorised wheelchair over longer distances

6. Do you use a mobility aid?
   Yes

7. If so, what type?
   Motorised wheelchair

Evaluation of results: Sonia's main form of mobility is a wheelchair, which equates to level 7 of the patient determined disease step. The Disease Steps Scale to be entered into the system is 6.

Time: 25 minutes (15 minutes for activity and 10 minutes for debrief)

Assessment not specific to a disability type

Display Slide 116

State: When there aren't any specific assessments for a person's disability, the PEDI-CAT or WHODAS would be completed.

The World Health Organisation Disability Assessment Schedule (WHODAS) is a series of questions for people 17 years of age and above. It assesses the individual's difficultly completing or undertaking tasks in different areas of their life. It helps us to understand the level of difficulty an individual experiences when doing different activities.

We complete the WHODAS assessment when we have no recorded evidence of other functional capacity assessments on file. We record the level of difficulty the participant has found when completing tasks in the past 30 days. The WHODAS can be used in addition to a disability-specific tool when required. This should not change the typical support package (TSP).

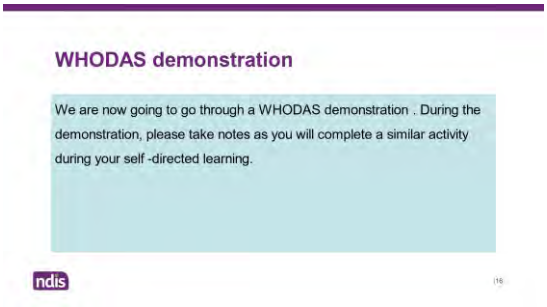
The PEDICAT is another assessment we can use for children. A PEDI-CAT assessment helps us understand a child's ability to complete tasks in their daily life.

We use the PEDI-CAT assessment with children younger than 6. Sometimes, we use PEDI-CAT for children aged 7-16 if there isn't another tool available.

Time: 2 minutes

WHODAS demonstration

Display Slide 117



Facilitator Note: We are now going to complete a WHODAS Demonstration.

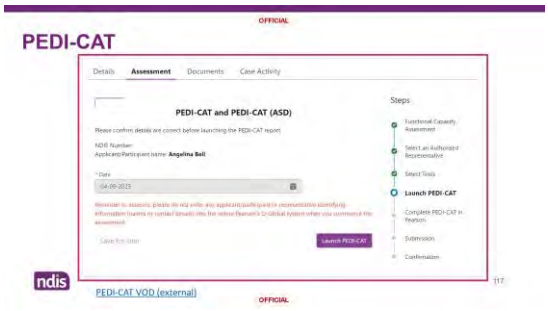
1. From the **Person Account**, in account view, select **Cases** tab.
2. Select **New** in the top-right corner of the cases panel.

3. Select **Functional Capacity Assessment**.
4. Select **Next**.
5. In **Categorisation** section, select **Origin**.
6. Select **Save**.
7. From the functional capacity assessment view, select **Assessment** tab.
8. Select **Next**.
9. Select **No** for an authorised representative.
10. Select **Next**.
11. At the **Select Tools** step in the Functional Capacity Assessment:
12. Select **Yes** to Carry out a new assessment.
13. Select **WHODAS 12**.
14. Select **No** to Manually enter scores.
15. Select **Next**.
16. Ask learners to help you answer the questions listed based on what they know about Sally. Move the sliding scale indicator to a score between 1 and 5. Answers for Sally should range between None-Moderate depending on how the learners have interpreted her information.
17. Select **Next**.
18. Check the Confirmation details.
19. Select **Done**.

Time: 10 minutes

PEDI-CAT

Display Slide 118



State: The Pediatric Evaluation of Disability Inventory Computer Adaptive Test (PEDI-CAT) is a functional capacity assessment that is not specific to a disability.

Completing the PEDI-CAT will support the measurement of severity change over time for consistent reporting.

You can complete the PEDI-CAT if you are an:

- Early Childhood Partner
- Local Area Coordinator
- NDIS planner
- NDIS plan delegate.

Note: For children under the EC approach (0-6 years) the PEDI-CAT is administered by the Early Childhood Partner only.

Check that the person needs the PEDI-CAT assessment tool. Children aged:

- **0-6:** must have the PEDI-CAT score in addition to any other assessment tool
- **7-16**: only need the PEDI-CAT if a more appropriate tool can be recorded.

Conduct the PEDI-CAT assessment with the person and/or their Child Representative.

Version Control

Version	Amended by	Description	Status	Date
V2.0	RWP064	Updated links, Edits	Draft	04/03/24
V2.1	SSN695	Updated Content	Draft	08/05/24
V2.2	SJT409	Updated Content	Draft	01/08/24
V2.3	AIA372	Legislation updates	Final	29/10/2024

Making Connections, Applying and Access

Learner Workbook: Answer Guide

The contents of this document are OFFICIAL.

This learner workbook answer guide is to support the training for the Frontline Essential facilitated modules. This answer guide supports facilitators in correcting the self-directed activities in the learner workbook.

Table of Contents

the top of the page. If you require additional support reach out to your buddy or team leader.

Task 26 – Functional capacity assessment case (WHODAS)

In the training environment locate the person account that you have been using in self directed learning and use knowledge articles to complete a Functional capacity case (WHODAS). Use the information in the appendix and the participant statement and goals that you have previously created for Sally Stevens to complete this task. Ensure that you are in the training environment before changing or creating any participant records. The way to check this is to ensure the words Sandbox:TRNENV appears in the heading band at the top of the page. If you require additional support reach out to your buddy or team leader.

Version Control

Version	Amended by	Description	Status	Date
V2.0	RWP064	Updated links, Edits	Draft	04/03/24
V2.1	SSN695	Updated Content	Draft	08/05/24
V2.2	SJT409	Updated Content	Draft	01/08/24
V2.3	AIA372	Legislation updates	Final	29/10/2024

ndis

Check-ins Program Guide Transition V2.2

The contents of this document are OFFICIAL.

Program guide to support the training for the Check-Ins facilitated modules.

This program guide provides additional information to the PowerPoint for facilitators.

Table of Contents

- Record request for internal review.

Group Three

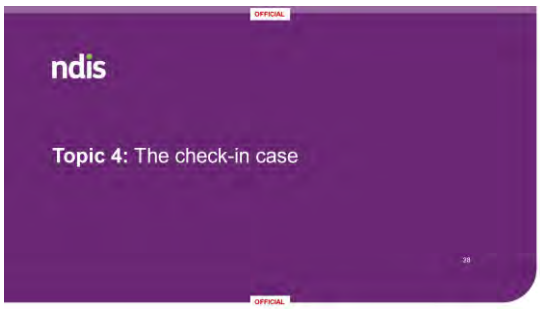
- Complete Personal and Environmental Circumstances.
- Update functional capacity assessment.
- Complete SFOF.
- Initiate eligibility reassessment.

Activity duration: 10 minutes activity + 5 minute debrief. Ask learners to post their table or a snip in the chat

Debrief: Did you find the relevant materials, were they easy to locate? Feel free to raise your hand if you would like to share or pop your response in the chat. Remember, our NDIA resources are updated regularly, so always make sure you are accessing the current version rather than saving a copy to your device.

Topic 4 The Check-in process in PACE

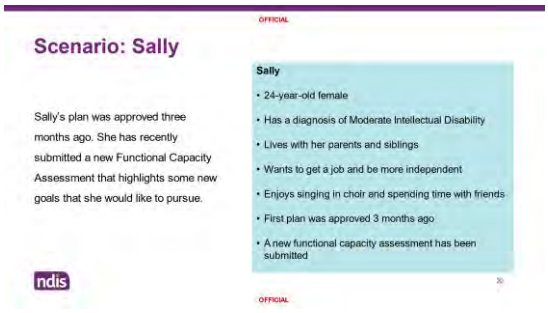
Display slide 27



State: Topic 4: The check-in case

Scenario: Sally

Display slide 28

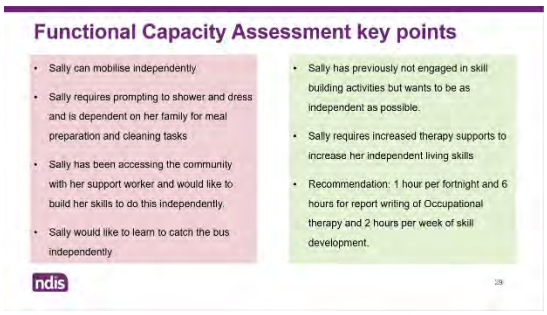


State: Sally is our participant who we met during the last couple of weeks of training. She is a 24-year-old female with a diagnosis of moderate intellectual disability. Sally's first plan was approved 3 months ago which included funding for a functional capacity assessment to assess her ongoing needs. We have now received the new functional capacity assessment which recommends an increase in supports to work towards some new goals. We need to discuss this with Sally in a check-in meeting.

Time: 2 minutes

Functional Capacity Assessment key points

Display slide 29



State: Here are some key points from the Functional Capacity Assessment report that we received before our check-in with Sally. These reports are usually quite long documents however we have picked out a few points here which we can use when considering a check-in conversation. Sally's Functional Capacity Assessment report states that Sally can mobilise independently. She requires prompting to shower and dress and is fully dependent on her family for meal preparation and cleaning tasks. Sally has been accessing the community with her support worker and would like to build her skills to do this independently. Sally would also like to learn to catch the bus independently. The report notes that Sally has not previously engaged in skill

building activities but wants to be as independent as possible in the future. The report states that Sally requires increased therapy supports to develop her independent living skills. The Occupational therapist has recommended 1 hour per fortnight of Occupational therapy and an additional 6 hours for report writing as well as 2 hours of skill development with a support worker in Sally's next plan.

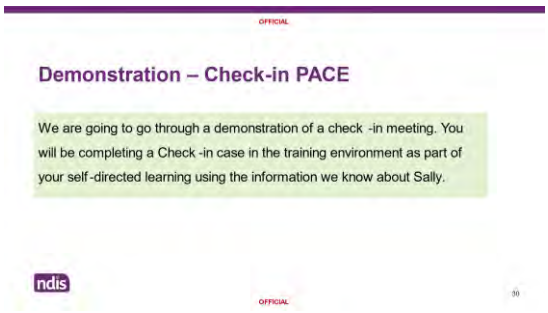
Ask: Are we required to include funding for all therapist recommendations in a participant plan?

Answer: No, support still need to be reasonable and necessary even if they are recommended by an Allied health professional.

Time: 5 minutes

Demonstration – Check-in PACE

Display slide 30



State: I am going to demonstrate how to complete the Check-in meeting for Sally using some examples of what could be included. It's important to remember that these are just examples and if you are unsure what to write or what to discuss in an check-in meeting you should refer to guidance in the knowledge articles or consult with your team leader or buddy. You will just be observing me complete this however you will practice this in the training environment after todays session.

If you need support or have any questions after this session your Team Leader or Buddy will go through this with you.

Facilitator Note:

1. From the **Person Account** screen, select **Cases**
2. Select **New**
3. Select **Check-in**
4. Select **Next**
5. At Reason Category, select from the drop down options
   For Sally select **participant initiated**
6. At the Reason Code, Select **Potential Changes to current plan**
7. Select **Save**

State: We will need to book the check in meeting to be able to proceed with the case.

8. From the Check-in case, navigate to the **Activity bar** on the right
9. Select **More**
10. Select **New event**
11. At Search People bar, your details will automatically populate
    Leave this as is
12. At **Start**, include the **date and time** of when the Check-in meeting is to occur
    For Sally leave the **default date and time**.
13. At **End**, leave the **default date and time**.

State: If this was for a real participant you would enter the agreed date and time of the check in conversation.

14. At **Assigned To**, your name will automatically populate
15. At **Subject**, Select **Check-in meeting** from the drop-down options
16. At **Description**, add in any additional notes.
    For Sally enter '**Check in due to new information provided**.'
17. At **Type**, select **phone**
18. At **Location**, include where the meeting is taking place
    For Sally enter **Phone**

19. At **Interpreter** required, **No**
20. Select **Save**.

State: Before commencing any case it's important to review the guidance for success.

Facilitator Note: Draw learners attention to the Guidance for success in the top left hand corner of the case.

21. In the **Check-in case**, select the **Check-in tab**.
22. Select **Yes** for Sally
23. At **During this check-in, will you be supporting the participant and/or their family to prepare for an upcoming scheduled plan reassessment?** Select **No**.
24. Select **Next**.
25. At **Participant and Authorised representatives**, select **Sally's** name and select the arrow facing right to move the name over to the **Attended** box
26. Select **Next**.
27. Review the About Me information.

State: In this section we can make updates to a persons About Me. Remember it's important for this to be in the participants own words.

28. Select **Next**
29. Demonstrate the goals screen.

Ask: Based on what we know about Sally can anyone think of a new goal she might want to add to her plan?

Field Answers

State: Sally might want to add that she wants to be able to take the bus by herself.

30. Select **Update**
31. In the **Update Request Info** screen at Update Requested by, select **Participant**

32. At **Update Reason**, select **person statement update**
33. Select **Next**
34. Select **New**
35. For **goal** enter: **I would like to be able to use the bus independently**.
36. For **how will I work towards this goal enter**: **I will work with my support team to develop my skills to manage money for the ticket price and learn where to get on and off so I don't get lost. My family will help me practice**.
37. Under this **goal relates to** select the boxes for **daily life and social and community activites.**
38. Select **Save**.
39. Select **Save**
40. Select **Next**
41. Display the **ICM s**upports screen

State: We won't make any updates for Sally in this section today.

42. Select **Next**
43. Review the Authorised Reps, Providers and Relationships tab to ensure the information is still current and correct. If any of these need to be updated it will need to be done outside of the check in case.
44. Select **Next**
45. On the **budget and funded supports** screen select **No**
46. Select **Next**
47. On the **Changes in situation screen** select **Abilities and function**
48. In the **record strategies** box enter: **Functional capacity assessment received. Discussion with Sally on how to build her functional capacity using her current funded supports and utilizing community and mainstream supports.**
49. Under **is the participant likely to need their eligibility reassessed** enter **No**
50. Select **Next**

Ask: From what we know about Sally are their any signs of risk?

Field Answers

State: Based on the information we know about Sally there are not signs of risk

51. Select **No**
52. Select **Next**
53. From the **Next Steps** screen of the check-in case, select the relevant checkboxes. The checkboxes you select will automatically create the cases when you submit the check-in

State: We are selecting **plan change** case here because we have new information about Sally's functional capacity.

Ask: If this were a real participant and we had just received a functional capacity assessment what other boxes might we select?

Answer: Complete personal and environment circumstance, Update functional capacity assessment, Complete SFOF. This is because we will have new information on the participants capacity which may change the answers to these questionaires.

54. At **are you scheduling the last check-in before a plan reassessment** select **No** (this is because the question is referring to scheduled reassessments.)
55. Leave the default check in date for this demonstration.
56. Select **next**
57. At **does the participant wish to receive a check in summary** select **no**.
58. Select **Next**
59. Review information and select **Submit**
60. If you receive an error message indicating that you can't progress due to tasks being open.
61. Select cancel
62. From the check in case select the **Case Activity tab**
63. Under the **Activity History** heading locate check in meeting
64. **Se**lect the drop down menu (arrow) on the right hand side

65. Select edit
66. Change event stage to completed
67. Select save
68. Go back to the check-in tab
69. Select submit

Table 2 – Version Control

Version	Description	Completed by	Date
1.0	First issue	KKL559	
1.1	Links added, spaces	Kht002	
1.2	Updated Slides Formatting of bullet points Slide numbering Timing table	Amelia s22(1)(a)(ii) - irr	
1.3	Alt text / formatting	FEA036	23-10-23
1.4	Links, spacing	KHT002	25-10-23
2.0	Links updated	MJK078	
2.1	Content Updated	RWP064	02/05/24
2.2	PACE demonstrations added	RWP064	05/09/24

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Frontline Essentials: Check-ins

Week 4: Day 2

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Session Outline

We will cover the following topics today:

Topic 1: Why we do check-ins and types of check-ins

Topic 2: Who completes a check-in

Topic 3: Resources

Topic 4: The check-in case

Topic 5: Transitioning existing participants plans from CRM to PACE

Learning Outcomes

In this session we will explore:

- Why we do check-ins with participants and the different types of check-ins.
- Who completes a check-in with a participant.
- The basics of the check-in process in PACE.
- Resources about participant check-ins.
- The transitioning participants plans from CRM to PACE process.

Topic 4: The check-in case

Scenario: Sally

Sally's plan was approved three months ago. She has recently submitted a new Functional Capacity Assessment that highlights some new goals that she would like to pursue.

- 24-year-old female
- Has a diagnosis of Moderate Intellectual Disability
- Lives with her parents and siblings
- Wants to get a job and be more independent
- Enjoys singing in choir and spending time with friends
- First plan was approved 3 months ago
- A new functional capacity assessment has been submitted

Functional Capacity Assessment key points

- Sally can mobilise independently
- Sally requires prompting to shower and dress and is dependent on her family for meal preparation and cleaning tasks
- Sally has been accessing the community with her support worker and would like to build her skills to do this independently
- Sally would also like to learn to catch the bus independently.

- Sally has not previously engaged in skill building activities but wants to be as independent as possible in the future.
- Sally requires increased therapy supports to develop her independent living skills
- Recommendation: 1 hour per fortnight and an additional 6 hours for report writing of Occupational Therapy. 2 Hours per week of skill development.

Demonstration – Check-in PACE

We are going to go through a demonstration of a check-in meeting. You will be completing a Check-in case in the training environment as part of your self-directed learning using the information we know about Sally.

Version Control

Version	Amended by	Description	Status	Date
Vers 2.0	MJK078 Maureen s22(1)(a)(ii) - Irrel	Updating Links	Updated	05/03/2024
2.1	RWP064	Content Update	Final	2/05/24
2.2	RWP064	PACE Demonstrations added	DRAFT	05/09/24

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Changes to your plan - Program Guide

The contents of this document are OFFICIAL.

Program guide to support the training for the Changes to your plan facilitated modules. This program guide provides additional information to the PowerPoint for facilitators.

Table of Contents

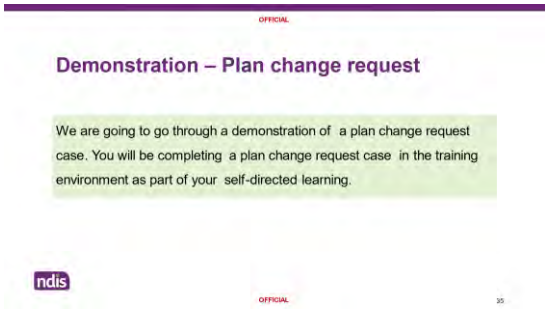
Topic 4: Plan changes in PACE

Display slide 31

State: You learned about a plan change request and a plan change case in these morning's self-directed eLearn, we are now going to look into this a bit more.

Demonstration: Plan Change Request

Display slide 32



State: I am going to demonstrate how to complete the plan change request case. It's important to remember that these are just examples, and you should refer to guidance in the knowledge articles or consult with your team leader or buddy. You will just be observing me complete this however you will practice this in the training environment after todays session.

If you need support or have any questions after this session your Team Leader or Buddy will go through this with you.

In this example, we have received a request from our participant Sally to initiate a plan reassessment, due to new functional capacity assessment being supplied and stating the plan no longer meets the participant's needs.

Initiate Request:

1. From the Person Account, select the Cases tab.
2. Select the plan change case from the list of open cases as we opened it during our check in case yesterday.

Plan change case:

1. In the plan change case, Select the request tab
2. Select Date (calendar) for Requested date. Leave it as the default date for the demonstration.
3. In How is the request being initiated? Select Participant requested - S48
4. In Who is requesting the plan change? Select Participant

Change in situation

1. In Changes in situation Select Functional capacity
2. In When did this change happen? Select a date in the last month

   State: We would enter this as the date of the report.
3. In Provide details of the situation type New functional capacity assessment received with a request for additional supports
4. If the new plan requires a change in fund management, select the checkbox next to Change to fund management required. For this example, leave unchecked
5. Select Next

Document/Evidence:

Ask: What evidence that is related to the plan change case would we need to add to the evidence tab when we are prompted in this section?

Answer: The Functional Capacity Assessment Report

1. Select next.

Risk Matrix:

If you don't identify any risks:

Ask: Have we identified any risks for Sally?

Answer: No

1. Select No.
2. Select Next to progress the case.

Request Confirmation:

1. Select confirm.
2. Select submit.
3. Plan change case is completed.

Demonstrate: Show learners that the plan has now changed queue as the decision is awaiting approval.

Time: 15 minutes

Table 2 – Version Control

Version	Amended by	Description	Status	Date
V1.0	Amelia [redacted]	First Issue	Final	23/10/2023
V1.1	Kate [redacted]	Edited slide numbers and links	Final	24/10/2023
V2.0	RWP064	Updated links	Final	07/03/24
V2.1	RWP064	Updated Content	Final	03/05/24
V2.2	RWP064	Added PACE demonstrations & Legislation changes	Draft	06/09/24

Frontline Essentials: Changes to your plan

Week 4 Day 3

Session outline

Topic 1: Legislation relating to plan changes

Topic 2: Who completes the plan change process

Topic 3: Plan changes

Topic 4: Plan changes in PACE

Topic 5: Leaving the NDIS

Topic 6: Eligibility reassessment

Topic 7: Internal review of decisions

Learning outcomes

Through this session we will:

- Explore the NDIS legislation that relates to plan changes
- Discover who completes the plan change process
- Compare plan change types; variations and reassessments
- View plan changes in PACE simulations
- Explore leaving the NDIS
- Explain eligibility reassessment
- Understand internal review of decisions

Topic 4: Plan Changes in PACE

Demonstration – Plan change request

We are going to go through a demonstration of a plan change request case. You will be completing a plan change request case in the training environment as part of your self-directed learning.

Version control

Version	Amended by	Description	Status	Date
V0.1	SRP102	New	Draft	19/10/2023
V1.0		First Issue	Final	23/10/2023
V2.0	RWP064	Updated	final	07/03/24
V2.1	RWP064	Updated	Final	03/05/24
V2.2	RWP064	Updated	Draft	06/09/24

Overview – Early childhood approach - Facilitator Guide

The contents of this document are OFFICIAL.

Facilitator guide to support the training for the Overview - Early childhood approach facilitated module.

This facilitator guide is for facilitators and supplements the PowerPoint.

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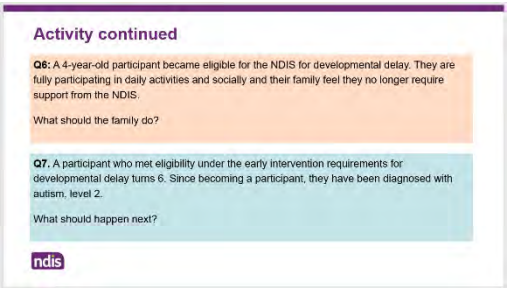
Activity continued 2

Display Slide 51



State:

Question 6: A 4-year-old participant became eligible for the NDIS for developmental delay. They are fully participating in daily activities and socially and their family feel they no longer require support from the NDIS. What should happen next?

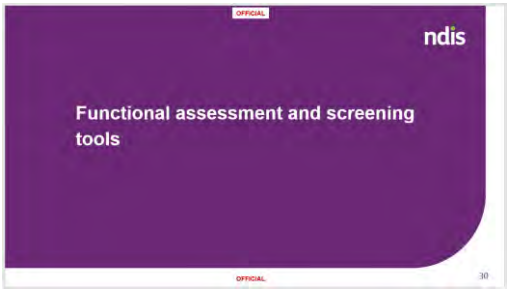
Answer: The early childhood partner should discuss voluntarily leaving the NDIS with the family and then support them with this.

Question 7: A participant who met eligibility under the early intervention requirements for developmental delay turns 6. Since becoming a participant, they have been diagnosed with autism, level 2. What should happen next?

Answer: They are referred for an eligibility reassessment and continue eligibility moving from meeting the early intervention requirements to disability requirements.

Topic 4: Functional assessment and screening

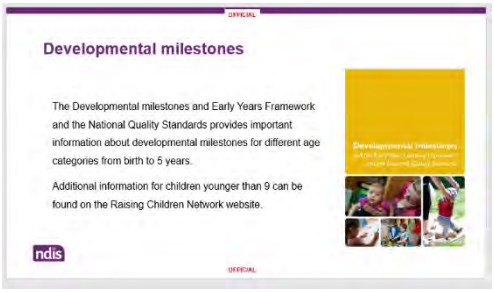
Display Slide 52



State: In this topic we will explore the functional assessment and screening tools. We will identify tools which may be used when considering the developmental skills and functional capacity of a child younger than 9.

Developmental milestones

Display Slide 53



Facilitator Note:

Place the links to the resources into the chat if training is delivered virtually.
The links will also be available in the learner workbook.
Developmental Milestones and the EYLF and NQS (external) and
Raising Children Network (external).

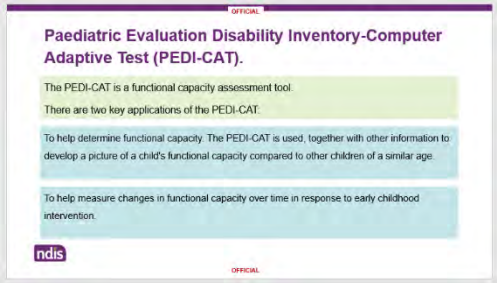
State:

The Developmental milestones and Early Years Framework and the National Quality Standards provide important information about developmental milestones for different age categories from birth to 5 years.

Whilst it is not a checklist of what all children should have reached by a particular age it provides examples of age-related milestones. This resource should be used as a source of information rather than a prescriptive checklist.
You can use it to help in your understanding of child development when considering participant information.
Additional information for children younger than 9 can be found on the Raising Children Network (external) website.

Paediatric Evaluation Disability Inventory Computer Adaptive Test (PEDI-CAT)

Display Slide 54



State:

The PEDI-CAT is a functional capacity assessment tool.

There are two key applications of the PEDI-CAT:

- To help determine functional capacity. The PEDI-CAT is used, together with other information to develop a picture of a child's functional capacity compared to other children of a similar age across four domains: daily activities, mobility, social/cognitive and responsibility.
- To help measure changes in functional capacity over time in response to early childhood intervention.

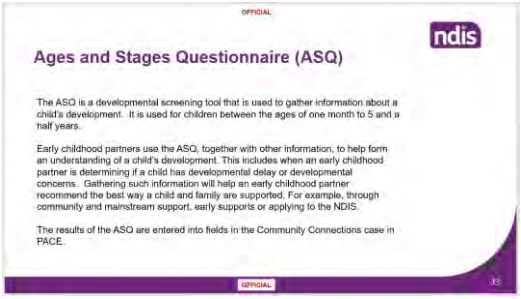
A PEDI-CAT can be completed when an early childhood partner is gathering information to understand the developmental profile of a child.

It must be administered by the early childhood partner before the commencement of, and at the completion of early supports. The PEDI-CAT is also administered when supporting a family of a child younger than 7 to apply for the NDIS using a Functional Capacity Assessment case in PACE. Also, for a participant younger than 7 at the check-in prior to the plan reassessment due date a PEDI-CAT will need to be completed.

However, it results of a recent PEDI-CAT are available, these can be recorded in PACE instead of completing a new PEDI-CAT.

Ages and stages questionnaire (ASQ)

Display Slide 55



State:

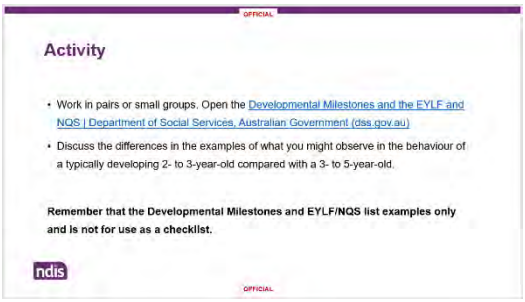
The ASQ is a developmental screening tool that is used to gather information about a child's development. It is used for children between the ages of one month to 5 and a half years.

Early childhood partners use the ASQ, together with other information, to help form an understanding of a child's development. This includes when an early childhood partner is determining if a child has developmental delay or developmental concerns. Gathering such information will help an early childhood partner recommend the best way a child and family are supported. For example, through community and mainstream/other government supports and services, early supports or applying to the NDIS.

The results of the ASQ are entered into fields in the Community Connections case in PACE.

Activity: Developmental milestones discussion

Display Slide 56



State:

Work in pairs or small groups. Open the Developmental Milestones and the EYLF and NQS (external).

Discuss the differences in the examples of what you might observe in the behaviour of a typically developing 2- to 3-year-old compared with a 3- to 5-year-old.

Remember that the Developmental Milestones and EYLF/NQS list examples only and is not for use as a checklist.

Time: 10 minutes

Topic 5: Case scenarios

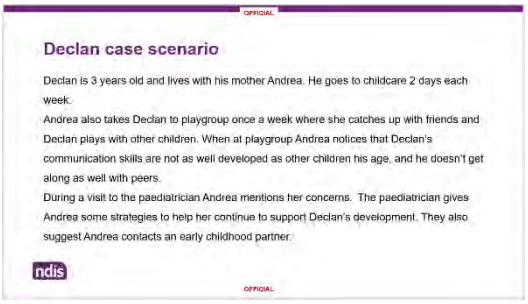
Display Slide 57

State:

We are now going to work on some case scenarios.

Declan case scenario

Display Slide 58



State:

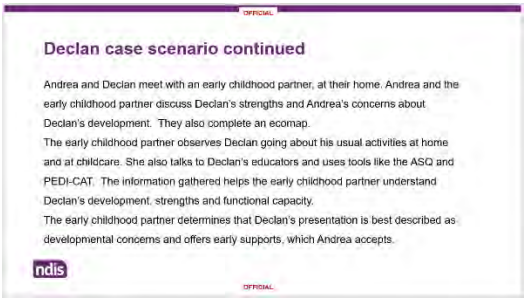
Declan is 3 years old and lives with his mother Andrea. He goes to childcare 2 days each week.

Andrea also takes Declan to playgroup once a week where she catches up with friends and Declan plays with other children. When at playgroup Andrea notices that Declan’s communication skills are not as well developed as other children his age, and he doesn’t get along as well with peers.

During a visit to the paediatrician Andrea mentions her concerns. The paediatrician gives Andrea some strategies to help her continue to support Declan's development. They also suggest Andrea contacts an early childhood partner.

Declan case scenario continued 1

Display Slide 59



State:

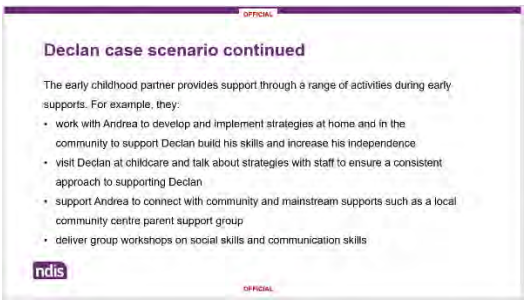
Andrea and Declan meet with an early childhood partner, at their home. Andrea and the early childhood partner discuss Declan's strengths and Andrea's concerns about Declan's development. They also complete an ecomap.

The early childhood partner observes Declan going about his usual activities at home and at childcare. She also talks to Declan's educators and uses tools like the ASQ and PEDI-CAT. The information gathered helps the early childhood partner understand Declan's development, strengths, and functional capacity.

The early childhood partner determines that Declan's presentation is best described as developmental concerns and offers early supports, which Andrea accepts.

Declan case scenario continued 2

Display Slide 60



State:

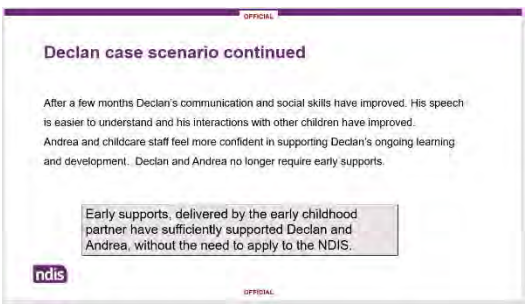
The early childhood partner provides support through a range of activities during early supports.

For example, they:

- work with Andrea to develop and implement strategies at home and in the community to support Declan build his skills and increase his independence.
- visit Declan at childcare and talk about strategies with staff to ensure a consistent approach to supporting Declan.
- support Andrea to connect with community and mainstream supports such as a local community centre parent support group.
- deliver group workshops on social skills and communication skills.

Declan case scenario continued 3

Display Slide 61



State:

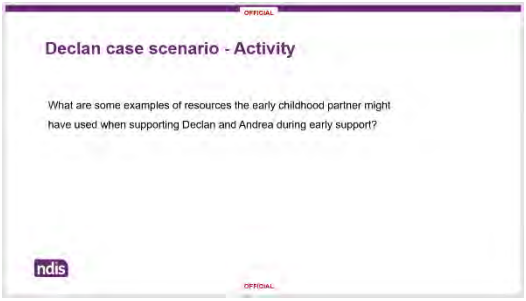
After a few months Declan's communication and social skills have improved. His speech is easier to understand and his interactions with other children have improved.

Andrea and childcare staff feel more confident in supporting Declan's ongoing learning and development. Declan and Andrea no longer require early supports.

Early supports, delivered by the early childhood partner have sufficiently supported Declan and Andrea, without the need to apply to the NDIS.

Activity Declan case scenario

Display Slide 62



State:

What are some examples of resources the early childhood partner might have used when supporting Declan and Andrea during early support?

Time: 5 minutes

Debrief

Examples could include:

Resources on the NDIA intranet Early connections (external) such as

- Booklet-Early childhood approach
- Tip Sheets. For example, on topics such as communication, play, behaviour, and best practice.
- The EC Applying best practice principles in early supports form.

Our Guideline - Mainstream and community supports (external)

Support for carers from other agencies (external)

Knowledge articles in PACE

Raising Children Network (external) website

Their established knowledge and network of local and national community and mainstream services.

Lucy case scenario

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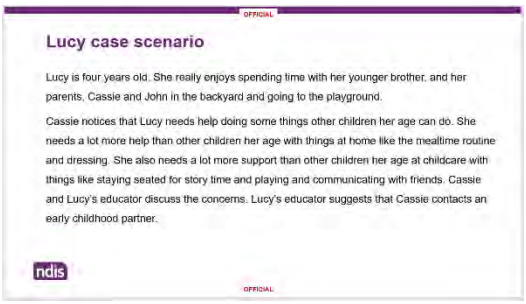

State:

Lucy is four years old. She really enjoys spending time with her younger brother, and her parents, Samantha and John in the backyard and going to the playground.

Samantha notices that Lucy needs help doing some things other children her age can do. She needs a lot more help than other children her age with things at home like the mealtime routine and dressing. She also needs a lot more support than other children her age at childcare with things like staying seated for story time and playing and communicating with friends. Samantha and Lucy's educator discuss the concerns. Lucy's educator suggests that Samantha contacts an early childhood partner.

Lucy case scenario continued 1

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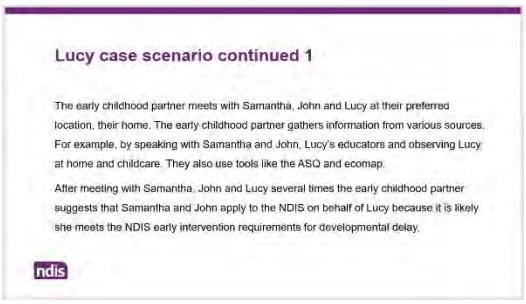

State:

The early childhood partner meets with Samantha, John and Lucy at their preferred location, their home. The early childhood partner gathers information from various sources. For example, by speaking with Samantha and John and Lucy's educators and observing Lucy at home and childcare. They also use tools like the ASQ and ecomap.

After meeting with Samantha, John, and Lucy several times the early childhood partner suggests that Samantha and John apply to the NDIS on behalf of Lucy because it is likely she meets the NDIS early intervention requirements for developmental delay.

Lucy case scenario continued 2

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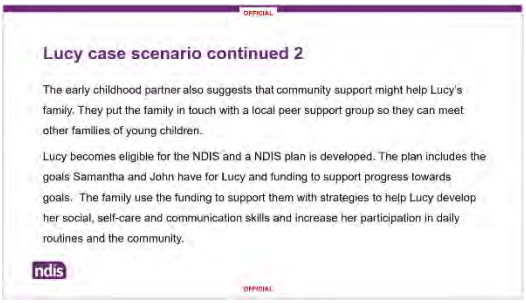

State:

The early childhood partner also suggests that community support might help Lucy's family. They put the family in touch with a local peer support group so they can meet other families of young children.

Lucy becomes eligible for the NDIS under the early intervention requirements and a NDIS plan is developed. The plan includes the goals Samantha and John have for Lucy and funding to support progress towards goals. The family use funding to get early intervention through a key worker who provides strategies to help Lucy develop her social, self-care and communication skills and increase her participation in daily routines and the community.

Lucy case scenario continued 3

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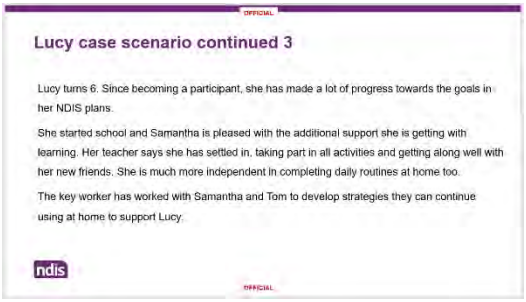

State:

Lucy turns 6. Since becoming a participant, she has made a lot of progress towards the goals in her NDIS plans.

She started school and Samantha is pleased with the additional support she is getting with learning. Her teacher says she has settled in, taking part in all activities, and getting along well with her new friends. She is much more independent in completing daily routines at home too.

The key worker has worked with Samantha and John to develop strategies they can continue using at home to support Lucy.

Lucy case scenario continued 4

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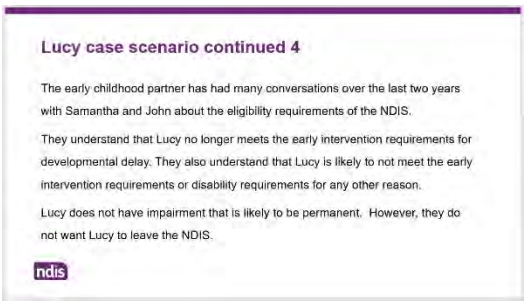

State:

The early childhood partner has had many conversations over the last two years with Samantha and John about the eligibility requirements of the NDIS.

They understand that Lucy no longer meets the early intervention requirements for developmental delay. They also understand that Lucy is unlikely to meet the early intervention requirements or disability requirements for any other reason. Lucy does not have an impairment that is likely to be permanent. However, they do not want Lucy to leave the NDIS.

Lucy case scenario continued 5

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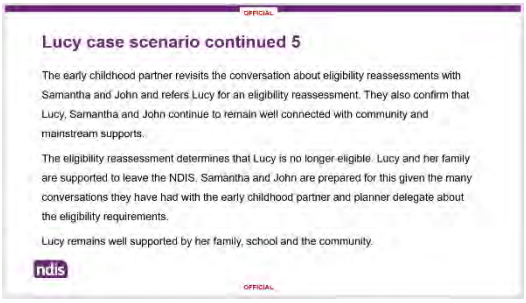

State:

The early childhood partner revisits the conversation about eligibility reassessments with Samantha and John and refers Lucy for an eligibility reassessment. They also

confirm that Lucy, Samantha, and John continue to remain well connected with community and other government supports and services.

The eligibility reassessment determines that Lucy is no longer eligible. Lucy and her family are supported to leave the NDIS. Samantha and John are prepared for this given the many conversations they have had with the early childhood partner and planner delegate about the eligibility requirements.

Lucy remains well supported by her family, school, and the community.

Lucy case scenario continued 6

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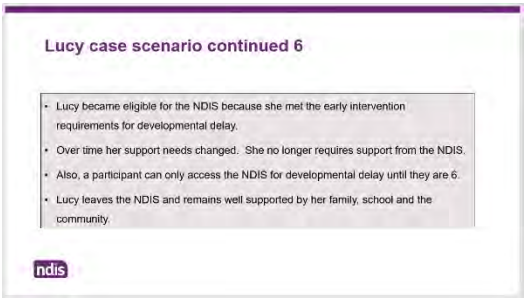

State:

- Lucy became eligible for the NDIS because she met the early intervention requirements for developmental delay.
- Over time her support needs changed. She no longer requires support from the NDIS.
- Also, a participant can only access the NDIS for developmental delay until they are 6.
- Lucy leaves the NDIS and remains well supported by her family, school, and the community.

Activity Lucy case scenario

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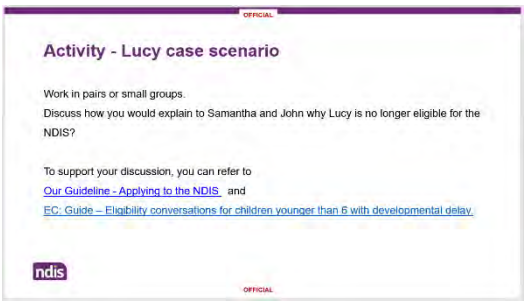


State:

Work in pairs or small groups. Discuss how you would explain to Samantha and John why Lucy is no longer eligible for the NDIS?
To support your discussion, you can refer to:
Our Guideline - Applying to the NDIS (external) and
EC: Guide – Eligibility conversations for children younger than 6 with developmental delay (external).
Time: 5 minutes

Debrief:
Here are some examples of the things that you should include in the conversation with Samantha and John when explaining why Lucy is likely to no longer be eligible for the NDIS:

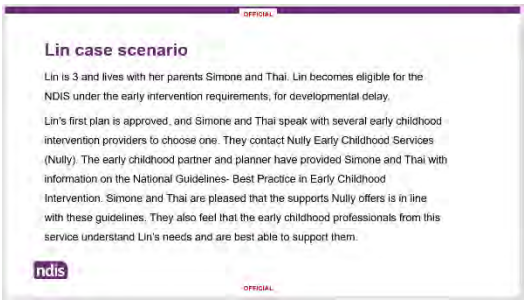
- A participant can only meet the early intervention requirements of the NDIS for developmental delay until they are 6 years old. As Lucy had turned 6, she cannot continue as a participant of the NDIS for developmental delay.
- Discuss Lucy's progress towards goals in her NDIS plan and her current functional capacity. Explain that Lucy is no longer likely to meet the early intervention requirements for developmental delay for reasons other than that she has turned 6. This is because what she can do now in everyday activities is similar to, or not significantly lower than what her same age peers can do. You could use:

What about children younger than 6 with developmental delay? (external) to help explain this to Samantha and John.

- Reiterate the role of community and mainstream supports in providing ongoing support to Lucy and her family, for example school with educational learning and the health system.
- Revisit the conversation about the early intervention and disability requirements for impairments that are likely to be permanent. Explain that as there is not any evidence that Lucy has an impairment that is likely to be permanent, she is unlikely to meet ongoing eligibility requirements.

Lin case scenario

Display Slide 71



State:

Lin is 3 and lives with her parents Simone and Thai. Lin becomes eligible for the NDIS under the early intervention requirements, for developmental delay.

Lin’s first plan is approved, and Simone and Thai speak with several early childhood intervention providers to choose one. They contact Nully Early Childhood Services (Nully). The early childhood partner and planner have provided Simone and Thai with information on best practice in early childhood intervention. Simone and Thai are pleased that the supports Nully offers is in line with best practice. They also feel that the early childhood professionals from this service understand Lin’s needs and are best able to support them.

Lin Case Scenario Continued 1

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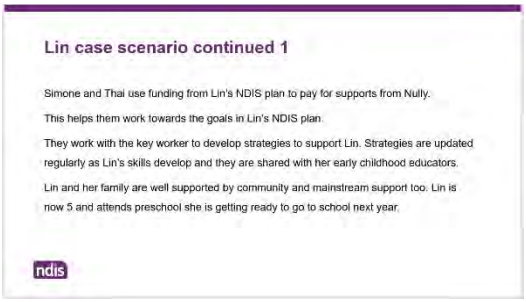
Lin case scenario continued 1



State:

Simone and Thai use funding from Lin's NDIS plan to pay for supports from Nully.

This helps them work towards the goals in Lin's NDIS plan.

Simone and Thai work with the key worker to develop strategies to support Lin. Strategies are updated regularly as Lin's skills develop and they are shared with her early childhood educators.

Lin and her family are well supported by community and other government supports and services too. Lin is now 5, attends preschool and she is getting ready to go to school next year.

Lin Case Scenario Continued 2

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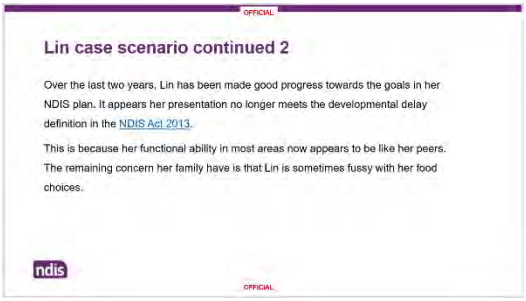

State:

Over the last two years, Lin has made good progress towards the goals in her NDIS plan. It appears her presentation no longer meets the developmental delay definition in the NDIS Act 2013 (External).

This is because her functional ability in most areas now appears to be like her peers. The remaining concern her family have is that Lin is sometimes fussy with her food choices.

Lin Case Scenario Continued 3

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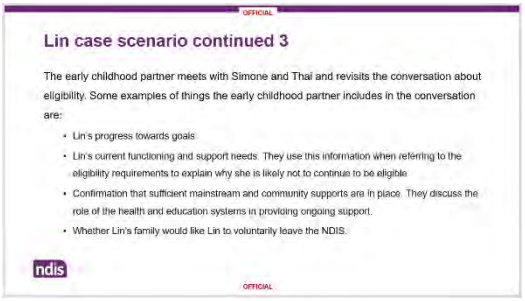


State:

The early childhood partner checks-in with Simone and Thai and revisit the previous eligibility conversations. Some examples of things the early childhood partner includes are:

- Lin’s progress towards goals.
- Lin’s current functioning and support needs. They use this information when referring to the eligibility requirements to explain why she is likely not to continue to be eligible.
- Confirmation that sufficient mainstream and community supports are in place. They discuss the role of the health and education systems in providing ongoing support.
- Whether Lin’s family would like Lin to voluntarily leave the NDIS.

Version Control

Version	Created by	Status	Date
V0.1	SRP102	New	11/12/2023
V1.0	SRP102	Final	01/02/2024
V2.0	SRP102	Final	01/03/24

Overview – Early childhood approach

For early childhood planners and early childhood partners

Session outline

In this session we will cover the following topics:

- **Topic 1:** Best practice in early childhood intervention
- **Topic 2:** The early childhood approach
- **Topic 3:** Eligibility for the NDIS
- **Topic 4:** Functional assessment and screening tools
- **Topic 5:** Case scenarios
- **Topic 6:** A family perspective
- **Topic 7:** Quiz

Learning outcomes

After completing this training, you will be able to:

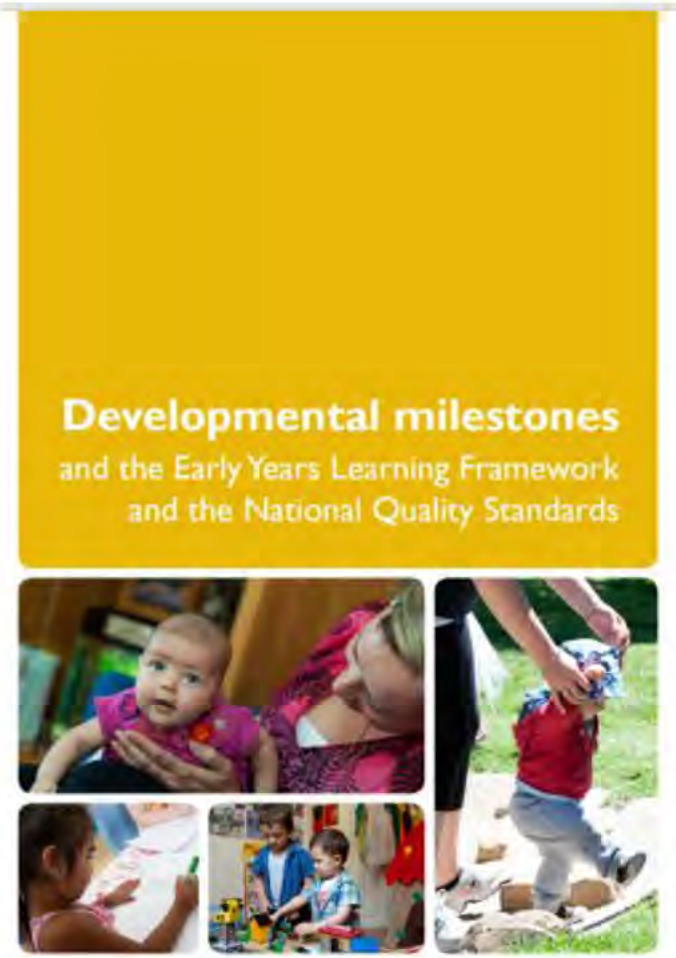
- Describe the early childhood approach, who it supports and how it benefits a child and family.
- Explain early connections and how they connect children and families to the support they need.
- Describe how the NDIS Code of Conduct, NDIS Practice Standards and National Guidelines-Best Practice in Early Childhood Intervention support the way we deliver the early childhood approach.
- Explain best practice in early childhood intervention to families.
- Explain the eligibility requirements and eligibility reassessment to families
- Identify tools which may be used when considering the developmental level and functional capacity of a child younger than 9.

Topic 4: Functional assessment and screening tools

Developmental milestones

The Developmental milestones and Early Years Framework and the National Quality Standards provides important information about developmental milestones for different age categories from birth to 5 years.

Additional information for children younger than 9 can be found on the Raising Children Network website.



Paediatric Evaluation Disability Inventory-Computer Adaptive Test (PEDI-CAT).

The PEDI-CAT is a functional capacity assessment tool.

There are two key applications of the PEDI-CAT:

To help determine functional capacity. The PEDI-CAT is used, together with other information to develop a picture of a child's functional capacity compared to other children of a similar age.

To help measure changes in functional capacity over time in response to early childhood intervention.

Ages and Stages Questionnaire (ASQ)

- The ASQ is a developmental screening tool that is used to gather information about a child's development. It is used for children between the ages of one month to 5 and a half years.
- Early childhood partners use the ASQ, together with other information, to help form an understanding of a child's development. This includes when an early childhood partner is determining if a child has developmental delay or developmental concerns. Gathering such information will help an early childhood partner recommend the best way a child and family are supported. For example, through community and other government supports and services, early supports or applying to the NDIS.
- The results of the ASQ are entered into fields in the Community Connections case in PACE.

Activity: Developmental milestones discussion

- Work in pairs or small groups. Open the Developmental Milestones and the EYLF and NQS | Department of Social Services, Australian Government (dss.gov.au) (External)
- Discuss the differences in the examples of what you might observe in the behaviour of a typically developing 2- to 3-year-old compared with a 3- to 5-year-old.

Remember that the Developmental Milestones and EYLF/NQS list examples only and is not for use as a checklist.

Topic 5: Case scenarios

Declan case scenario

Declan is 3 years old and lives with his mother Andrea. He goes to childcare 2 days each week.

Andrea also takes Declan to playgroup once a week where she catches up with friends and Declan plays with other children. When at playgroup Andrea notices that Declan's communication skills are not as well developed as other children his age, and he doesn't get along as well with peers.

During a visit to the paediatrician Andrea mentions her concerns. The paediatrician gives Andrea some strategies to help her continue to support Declan's development. They also suggest Andrea contacts an early childhood partner.

Declan case scenario continued 1

Andrea and Declan meet with an early childhood partner, at their home. Andrea and the early childhood partner discuss Declan's strengths and Andrea's concerns about Declan's development. They also complete an ecomap.

The early childhood partner observes Declan going about his usual activities at home and at childcare. She also talks to Declan's educators and uses tools like the ASQ and PEDI-CAT. The information gathered helps the early childhood partner understand Declan's development, strengths and functional capacity.

The early childhood partner determines that Declan's presentation is best described as developmental concerns and offers early supports, which Andrea accepts.

Declan case scenario continued 2

The early childhood partner provides support through a range of activities during early supports. For example, they:

- Work with Andrea to develop and implement strategies at home and in the community to support Declan build his skills and increase his independence.
- Visit Declan at childcare and talk about strategies with staff to ensure a consistent approach to supporting Declan.
- Support Andrea to connect with community supports such as a local community centre parent support group.
- Deliver group workshops on social skills and communication skills.

Declan case scenario continued 3

After a few months Declan's communication and social skills have improved.

His speech is easier to understand and his interactions with other children have improved.

Andrea and childcare staff feel more confident in supporting Declan's ongoing learning and development. Declan and Andrea no longer require early supports.

Early supports, delivered by the early childhood partner have sufficiently supported Declan and Andrea, without the need to apply to the NDIS.

Activity - Declan case scenario

What are some examples of resources the early childhood partner might have used when supporting Declan and Andrea during early support?

Lucy case scenario

Lucy is four years old. She really enjoys spending time with her younger brother, and her parents, Samantha and John in the backyard and going to the playground.

Samantha notices that Lucy needs help doing some things other children her age can do. She needs a lot more help than other children her age with things at home like the mealtime routine and dressing. She also needs a lot more support than other children her age at childcare with things like staying seated for story time and playing and communicating with friends. Samantha and Lucy's educator discuss the concerns. Lucy's educator suggests that Samantha contacts an early childhood partner.

Lucy case scenario continued 1

The early childhood partner meets with Samantha, John and Lucy at their preferred location, their home. The early childhood partner gathers information from various sources. For example, by speaking with Samantha and John and Lucy's educators and observing Lucy at home and childcare. They also use tools like the ASQ and ecomap.

After meeting with Samantha, John and Lucy several times the early childhood partner suggests that Samantha and John apply to the NDIS on behalf of Lucy because it is likely she meets the NDIS early intervention requirements for developmental delay.

Lucy case scenario continued 2

The early childhood partner also suggests that community support might help Lucy's family. They put the family in touch with a local peer support group so they can meet other families of young children.

Lucy becomes eligible for the NDIS under the early intervention requirements and a NDIS plan is developed. The plan includes the goals Samantha and John have for Lucy and funding to support progress towards goals. The family use funding to get early intervention through a key worker who provides strategies to help Lucy develop her social, self-care and communication skills and increase her participation in daily routines and the community.

Lucy case scenario continued 3

Lucy turns 6. Since becoming a participant, she has made a lot of progress towards the goals in her NDIS plans.

She started school and Samantha is pleased with the additional support she is getting with learning. Her teacher says she has settled in, taking part in all activities and getting along well with her new friends. She is much more independent in completing daily routines at home too.

The key worker has worked with Samantha and John to develop strategies they can continue using at home to support Lucy.

Lucy case scenario continued 4

The early childhood partner has had many conversations over the last two years with Samantha and John about the eligibility requirements of the NDIS.

They understand that Lucy no longer meets the early intervention requirements for developmental delay. They also understand that Lucy is unlikely to meet the early intervention requirements or disability requirements for any other reason. Lucy does not have an impairment that is likely to be permanent. However, they do not want Lucy to leave the NDIS.

Lucy case scenario continued 5

The early childhood partner revisits the conversation about eligibility reassessments with Samantha and John and refers Lucy for an eligibility reassessment. They also confirm that Lucy, Samantha and John continue to remain well connected with community and other government supports and services.

The eligibility reassessment determines that Lucy is no longer eligible. Lucy and her family are supported to leave the NDIS. Samantha and John are prepared for this given the many conversations they have had with the early childhood partner and planner delegate about the eligibility requirements.

Lucy remains well supported by her family, school and the community.

Lucy case scenario continued 6

- Lucy became eligible for the NDIS because she met the early intervention requirements for developmental delay.
- Over time her support needs changed. She no longer requires support from the NDIS.
- Also, a participant can only access the NDIS for developmental delay until they are 6.
- Lucy leaves the NDIS and remains well supported by her family, school and the community.

Activity - Lucy case scenario

Work in pairs or small groups.

Discuss how you would explain to Samantha and John why Lucy is no longer eligible for the NDIS.

To support your discussion, you can refer to:

Our Guideline - Applying to the NDIS (External) and

EC: Guide – Eligibility conversations for children younger than 6 with developmental delay (External).

Lin case scenario

Lin is 3 and lives with her parents Simone and Thai. Lin becomes eligible for the NDIS under the early intervention requirements, for developmental delay.

Lin's first plan is approved, and Simone and Thai speak with several early childhood intervention providers to choose one. They contact Nully Early Childhood Services (Nully). The early childhood partner and planner have provided Simone and Thai with information on best practice in early childhood intervention. Simone and Thai are pleased that the supports Nully offers is in line with best practice. They also feel that the early childhood professionals from this service understand Lin's needs and are best able to support them.

Lin case scenario continued 1

Simone and Thai use funding from Lin's NDIS plan to pay for supports from Nully.

This helps them work towards the goals in Lin's NDIS plan.

Simone and Thai work with the key worker to develop strategies to support Lin. Strategies are updated regularly as Lin's skills develop and they are shared with her early childhood educators.

Lin and her family are well supported by community and other government supports and services too. Lin is now 5, attends preschool and she is getting ready to go to school next year.

Lin case scenario continued 2

Over the last two years, Lin has made good progress towards the goals in her NDIS plan. It appears her presentation no longer meets the developmental delay definition in the NDIS Act 2013 (External).

This is because her functional ability in most areas now appears to be like her peers. The remaining concern her family have is that Lin is sometimes fussy with her food choices.

Lin case scenario continued 3

The early childhood partner meets with Simone and Thai and revisits the conversation about eligibility. Some examples of things the early childhood partner includes in the conversation are:

- Lin's progress towards goals.
- Lin's current functioning and support needs. They use this information when referring to the eligibility requirements to explain why she is likely not to continue to be eligible.
- Confirmation that sufficient community and other government supports and services are in place. They discuss the role of the health and education systems in providing ongoing support.
- Whether Lin's family would like Lin to voluntarily leave the NDIS.

Lin case scenario continued 4

Simone and Thai decide Lin will voluntarily leave the NDIS. They let the NDIS know of their decision by completing a form which is available on the NDIS website. They also could have done this by sending a letter or email if they preferred.

They will continue to get support from their general practitioner and community health dietician to manage Lin's diet and nutritional needs.

They will also continue to be supported by preschool this year, and school next year.

If Simone and Thai had not chosen to voluntarily leave, the early childhood partner would have referred Lin for an eligibility reassessment.

Lin case scenario continued 5

- Lin became eligible for the NDIS because she met the early intervention requirements for developmental delay.
- Some participants remain eligible for the NDIS for developmental delay until they are 6.
- Over time Lin's functional capacity increases. When she is 5, she no longer meets the early intervention requirements for developmental delay.
- Lin leaves the NDIS and remains well supported by her family and community and other government supports and services.

Activity: Lin case scenario

Discuss the case scenario about Lin in small groups or pairs.

Include in your discussion how you would explain to Simone and Thai the option of voluntarily leaving the NDIS.

Beth case scenario

Beth is 6 years old. She really enjoys gymnastics, and dancing around the house with her siblings. Ballet classes are the highlight of her week.

Beth became a participant of the NDIS following an autism diagnosis. Her parents have been using funding from Beth's NDIS plan for early childhood supports from a registered NDIS provider, Bright Children's Services. The key worker has been working with Beth's parents to develop strategies to support Beth to build her social, communication and fine motor skills and also with strategies to help her with emotional regulation.

Beth's parents, school and Bright Children's Services have been sharing strategies to ensure there is consistency in the way they support Beth across all environments. She has been progressing towards the goals in her NDIS plan.

Now that Beth has commenced school her parents have both moved to working full time. Since then, the key worker has solely been providing support through seeing Beth at school and sharing strategies with her educators.

Activity- Beth case scenario

What are some of the things you could say to Beth's parents about this?

In your response, consider the NDIS Practice Standards and Quality Indicators and the Best Practice Guidelines.

Version control

Version	Created by	Status	Date
V0.1	SRP102	Draft	Jan 2024
V1.0	SRP102	Final	05/02/2024
V2.0	SRP102	Final	01/03/2024

ndis

Overview- Early childhood approach

Learner Workbook

Contents

Question	Answer
became eligible for the NDIS because they met which criteria?	
Question 3: An 8-year-old child with Rett syndrome became eligible for the NDIS because they met which criteria?	Write here
Question 4: A participant who does not have evidence of an impairment that is likely to be permanent turns six. They became eligible for the NDIS for developmental delay. Following an eligibility reassessment, what will happen?	Write here
Question 5: A 5-year-old participant who became eligible for their NDIS, for developmental delay, has built their capacity and their presentation no longer meets the definition for developmental delay. They also do not have an impairment that is likely to be permanent. After discussions with the family about the eligibility requirements the family do not wish their child to voluntarily leave. What should happen next?	Write here
Question 6: A 4-year-old participant became eligible for the NDIS for developmental delay. They are fully participating in daily and community activities and their family feel they no longer require support from the NDIS. What should the family do?	Write here
Question 7: A participant who met eligibility under the early intervention requirements for	Write here

Question	Answer
developmental delay turns six. Since becoming a participant, they have been diagnosed with autism, level 2. What should happen next?	

Eligibility reassessment resources

Here are the links to some useful knowledge articles.
Remember you can also search for knowledge articles once you have access to PACE.
Make some notes about the key messages.
EC: Guide – Eligibility conversations for children younger than 6 with developmental delay | Salesforce (mcas.ms) and

EC: Guide – Evidence sources to demonstrate if an impairment is likely to be permanent for children who previously met access for developmental delay | Salesforce (mcas.ms)

Notes:

Topic 4: Functional assessment and screening

Read about developmental milestones and the Raising Children Network and make some notes about the key messages.

Fill in the reference and notes and questions table below.

Reference and notes and questions table

References	Notes and questions
Developmental Milestones and the EYLF and NQS (external)	Write here

References	Notes and questions
Department of Social Services > Our Responsibilities > Families and Children > Publications & Articles > Developmental Milestones and the EYLF and NQS	
Raising Children Network (external). raisingchildren.net.au	Write here

Activity: Developmental milestones discussion

Work in pairs or small groups. Open the Developmental Milestones and the EYLF and NQS (external)

Discuss the differences in the examples of what you might observe in the behaviour of a typically developing 2- to 3-year-old compared with a 3- to 5-year-old.

Remember that the Developmental Milestones and EYLF/NQS list examples only and is not for use as a checklist.

Topic 5: Case scenarios

Let's have a look at some case scenarios.

Declan case scenario

Declan is 3 years old and lives with his mother Andrea. He goes to childcare 2 days each week.

Andrea also takes Declan to playgroup once a week where she catches up with friends and Declan plays with other children. When at playgroup Andrea notices that Declan's communication skills are not as well developed as other children his age, and he doesn't get along as well with peers.

During a visit to the paediatrician Andrea mentions her concerns. The paediatrician gives Andrea some strategies to help her continue to support Declan's development. They also suggest Andrea contacts an early childhood partner.

Andrea and Declan meet with an early childhood partner, at their home. Andrea and the early childhood partner discuss Declan's strengths and Andrea's concerns about Declan's development. They also complete an ecomap.

The early childhood partner observes Declan going about his usual activities at home and at childcare. She also talks to Declan's educators and uses tools like the ASQ and PEDI-CAT. The information gathered helps the early childhood partner understand Declan's development, strengths, and functional capacity.

The early childhood partner determines that Declan's presentation is best described as developmental concerns and offers early supports, which Andrea accepts.

The early childhood partner provides support through a range of activities during early supports.

For example, they:

- work with Andrea to develop and implement strategies at home and in the community to support Declan build his skills and increase his independence.

- visit Declan at childcare and talk about strategies with staff to ensure a consistent approach to supporting Declan.
- support Andrea to connect with community supports such as a local community centre parent support group.
- deliver group workshops on social skills and communication skills.

After a few months Declan's communication and social skills have improved. His speech is easier to understand and his interactions with other children have improved.

Andrea and childcare staff feel more confident in supporting Declan's ongoing learning and development. Declan and Andrea no longer require early supports.

Early supports, delivered by the early childhood partner have sufficiently supported Declan and Andrea, without the need to apply to the NDIS.

Question: What are some examples of resources the early childhood partner might have used when supporting Declan and Andrea during early support?

Notes:

Lucy case scenario

Lucy is four years old. She really enjoys spending time with her younger brother, and her parents, Samantha and John in the backyard and going to the playground.

Samantha notices that Lucy needs help doing some things other children her age can do. She needs a lot more help than other children her age with things at home like the mealtime routine and dressing. She also needs a lot more support than other children her age at childcare with things like staying seated for story time and playing and communicating with friends. Samantha and Lucy's educator discuss the concerns. Lucy's educator suggests that Samantha contacts an early childhood partner.

The early childhood partner meets with Samantha, John and Lucy at their preferred location, their home. The early childhood partner gathers information from various sources. For example, by speaking with Samantha and John and Lucy's educators and observing Lucy at home and childcare. They also use tools like the ASQ and ecomap.

After meeting with Samantha, John, and Lucy several times the early childhood partner suggests that Samantha and John apply to the NDIS on behalf of Lucy because it is likely she meets the NDIS early intervention requirements for developmental delay.

The early childhood partner also suggests that community support might help Lucy's family. They put the family in touch with a local peer support group so they can meet other families of young children.

Lucy becomes eligible for the NDIS under the early intervention requirements and a NDIS plan is developed. The plan includes the goals Samantha and John have for Lucy and funding to support progress towards goals. The family use funding to get early intervention through a key worker who provides strategies to help Lucy develop her social, self-care and communication skills and increase her participation in daily routines and the community.

Lucy turns 6. Since becoming a participant, she has made a lot of progress towards the goals in her NDIS plans.

She started school and Samantha is pleased with the additional support she is getting with learning. Her teacher says she has settled in, taking part in all activities, and getting along well with her new friends. She is much more independent in completing daily routines at home too.

The key worker has worked with Samantha and John to develop strategies they can continue using at home to support Lucy.

The early childhood partner has had many conversations over the last two years with Samantha and John about the eligibility requirements of the NDIS.

They understand that Lucy no longer meets the early intervention requirements for developmental delay. They also understand that Lucy is unlikely to meet the early intervention requirements or disability requirements for any other reason. Lucy does not have an impairment that is likely to be permanent. However, they do not want Lucy to leave the NDIS.

The early childhood partner revisits the conversation about eligibility reassessments with Samantha and John and refers Lucy for an eligibility reassessment. They also confirm that Lucy, Samantha, and John continue to remain well connected with community and other government supports and services.

The eligibility reassessment determines that Lucy is no longer eligible. Lucy and her family are supported to leave the NDIS. Samantha and John are prepared for this given the many conversations they have had with the early childhood partner and planner delegate about the eligibility requirements.

Lucy remains well supported by her family, school, and the community.

- Lucy became eligible for the NDIS because she met the early intervention requirements for developmental delay.
- Over time her support needs changed. She no longer requires support from the NDIS.

- Also, a participant can only access the NDIS for developmental delay until they are 6.
- Lucy leaves the NDIS and remains well supported by her family, school, and the community.

Activity: Work in pairs or small groups. Discuss how you would explain to Samantha and John why Lucy is no longer eligible for the NDIS.

To support your discussion, you can refer to:

Our Guideline - Applying to the NDIS (external) and

EC: Guide – Eligibility conversations for children younger than six with developmental delay.

Notes:

Lin case scenario

Lin is 3 and lives with her parents Simone and Thai.

Lin becomes eligible for the NDIS under the early intervention requirements, for developmental delay.

Lin's first plan is approved, and Simone and Thai speak with several early childhood intervention providers to choose one.

They contact Nully Early Childhood Services (Nully).

The early childhood partner and the planner have provided Simone and Thai with information on best practice in early childhood intervention.

Simone and Thai are pleased that the supports Nully offers is in line with best practice.

They feel that the early childhood professionals from this service understand Lin's needs and are best able to support them.

Simone and Thai use funding from Lin's NDIS plan to pay for supports from Nully.

This helps them work towards the goals in Lin's NDIS plan.

Simone and Thai work with the key worker to develop strategies to support Lin. Strategies are updated regularly as Lin's skills develop and they are shared with her early childhood educators.

Lin and her family are well supported by community and other government supports and services too. Lin is now 5, attends preschool and she is getting ready to go to school next year.

Over the last two years, Lin has made good progress towards the goals in her NDIS plan.

It appears her presentation may no longer meet the developmental delay definition in the NDIS Act 2013.

This is because her functional ability in most areas now appears to be like her peers. The remaining concern her family have is that Lin is sometimes fussy with her food choices.

The early childhood partner meets with Simone and Thai and revisits the conversation about eligibility. Some examples of things the early childhood partner includes in the conversation are:

- Lin's progress towards goals.
- Lin's current functioning and support needs. They use this information when referring to the eligibility requirements to explain why she is likely not to continue to be eligible.
- Confirmation that sufficient community and other government supports and services are in place. They discuss the role of the health and education systems in providing ongoing support.
- Whether Lin's family would like Lin to voluntarily leave the NDIS.

Simone and Thai decide Lin will voluntarily leave the NDIS.

They let the NDIS know of their decision by completing a form which is available on the NDIS website.

They also could have done this by sending a letter or email if they preferred.

They will continue to get support from their general practitioner and community health dietician to manage Lin's diet and nutritional needs.

They will also continue to be supported by preschool this year, and school next year.

If Simone and Thai had not chosen to voluntarily leave, the early childhood partner would have referred Lin for an eligibility reassessment.

- Lin became eligible for the NDIS because she met the early intervention requirements for developmental delay.

National Disability Insurance Agency

ndis.gov.au

Telephone 1800 800 110

Webchat ndis.gov.au

Follow us on our social channels

Facebook, Twitter, Instagram, YouTube, LinkedIn

For people who need help with English

TIS: 131 450

For people who are deaf or hard of hearing

TTY: 1800 555 677

Voice relay: 1800 555 727

National Relay Service: relayservice.gov.au

Version Control

Version control table

Version	Amended by	Description	Status	Date
V0.1	SRP102	New	Draft	11/12/2023
V1.0	SRP102	Updated	Draft	05/02/2023
V2.0	SRP102	Updated	Final	01/03/2024

CI Connect – Severity Tools

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1. CI Connect – Severity Tools

Accessibility Options

Lesson 1 of 6

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Severity Indicator - Setting the Scene

Lesson 2 of 6

Pre-planning

Pre-planning is where you gather information from a participant or their carers and nominees. Your conversations are integral to deliver a positive participant experience. Your conversations help you to get the right information about the way a participant lives their day-to-day life, what they can do, their goals and supports.

You are all aware of the five Engagement Principles from our Participant Service Charter. They are:

Two are particularly important in the application of the content of this CI Connect module.

Responsive – We will respond to individual needs and circumstances

Respectful – We will recognise your individual experience and acknowledge you are an expert in your own life

When applying the “must dos” of Pre-Planning, it is very important to remember our Engagement Principles and that you deliver a quality, strengths based, participant-

centred conversation so that the participant feels listened to, respected and empowered at the end of the conversation.

The Update the Severity Tools task is one of two Pre-Planning tasks that contribute to the generation of the Typical Support Package (TSP). These two tasks are:

- Update Severity Tools
- Update the Guided Planning Questions

The primary disability is the disability with the greatest functional impact. The primary disability also contributes to the generation of the TSP. It is important at the Pre-Planning stage to confirm that the primary disability is correct and that evidence is available to confirm the primary and any secondary disability.

Correct severity tool choice, correct scoring and recording, correct responses to the Guided Planning Questions and a correct primary disability, ensures the integrity of the participant's Typical Support Package and plan. Data from quality checking of recently approved plans demonstrates that when this information is correct and evidence based, the funding decisions are more likely to meet all criteria in Section 34.1 of the NDIS Act 2013.

Note that for children 7 years and under the Guided Planning Questions are used to guide decision-making, not generate a TSP.

Does the TSP matter?

You may recall that the first principle Fair for everyone, both today and for future generations from the document "Principles we follow to create your plan" discusses the Typical Support Package. The information below is written for participants, however, it is a reminder for plan developers that the two Pre-Planning tasks that generate a Typical Support Package do matter and must be correct.

"The Typical Support Package gives us **an indication of what supports we'd usually expect to include in your plan** based on the participant's situation and disability support needs.

Each support in a plan must be reasonable and necessary, but they also need to be reasonable and necessary as a package of supports. We approve your whole plan, not the individual supports in a plan in isolation. The Typical Support Package **helps guide this validation process**.

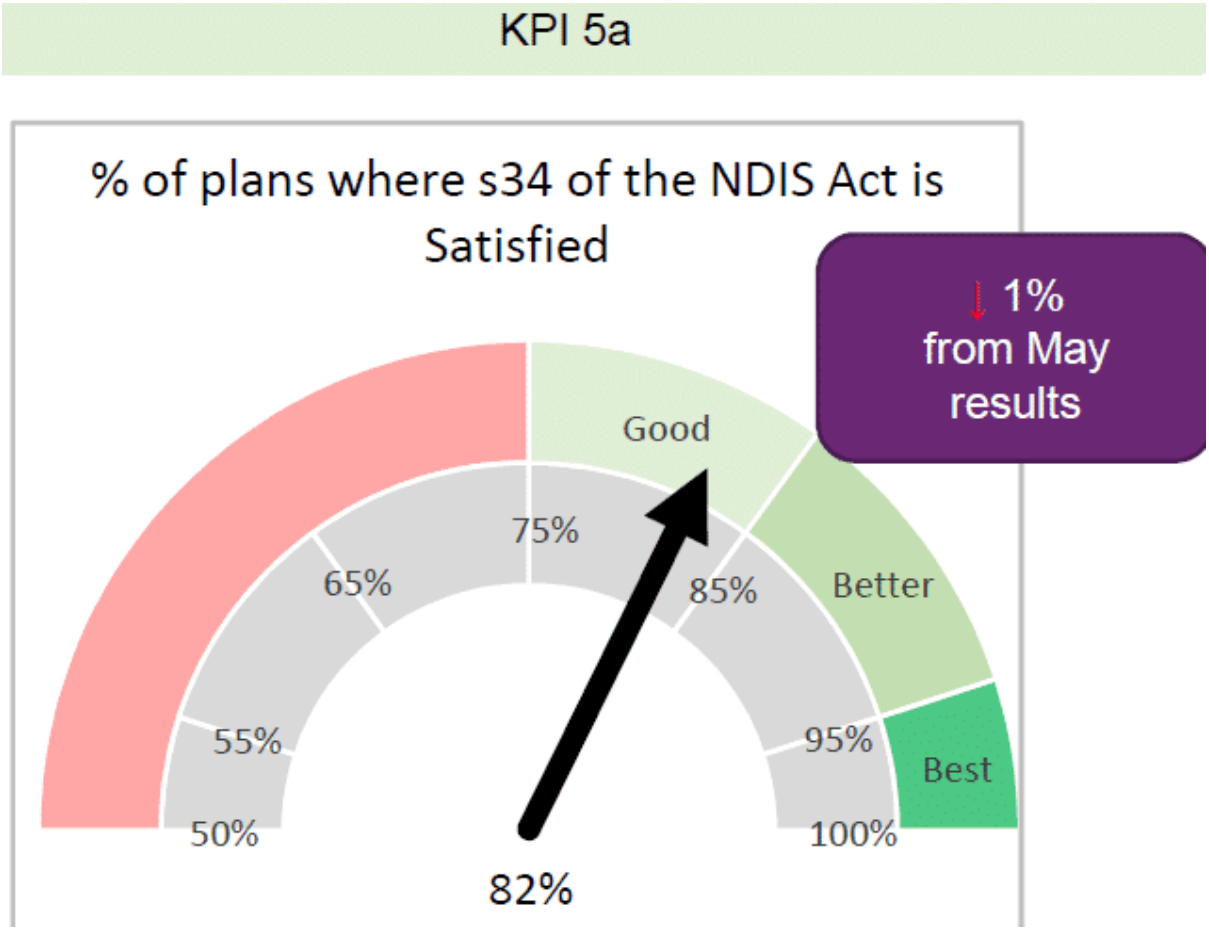
The Typical Support Package also **helps to guide the consistency of our decision making process.** We use these to check the overall plan to make sure that all the supports make sense together, and that the support types and amounts will complement each other to help participant's fulfil "an ordinary life."

The Problem - What does the data show?

Lesson 3 of 6

What does the data tell us?

The graph below shows the June 2021 result for KPI 5a - % of plans where Section 34.1 of the NDIS Act is satisfied. Good, better and best ranges are represented by colours. This graph was used in all the previous CI Connect modules. We are in the good range at 82% nationally for Reasonable and Necessary decision-making.



Severity Tools and WHODAS - Percentage of compliance

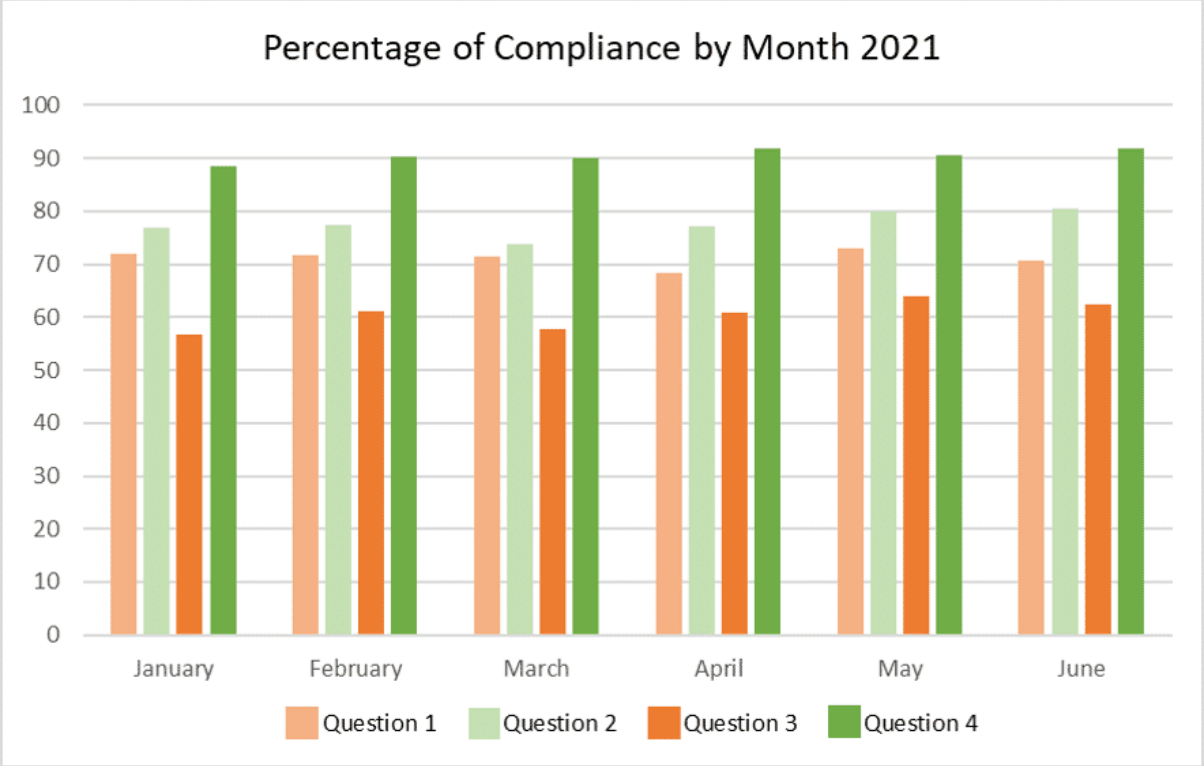
The graph below shows the results from 500 - 600 approved plans from January to June 2021 for three Pre-Planning tasks, as well as for whether the primary disability is correct.

The vertical axis shows percentages.

The horizontal axis shows the different months from January to June 2021.

The four colours represent four questions, and also where they are situated in the good, better, best range (as shown by the KPI 5a graph above). Orange means not yet in that range while green means they have achieved a good or better range.

The bar graphs below represent the results of quality checks for each question from January to June 2021.



The four questions are as follows:

Question 1 – Have the Guided Planning Questions been fully completed and do these responses appropriately reflect available information?

The pale orange bar graph shows the percentage of compliance with this question from January to June 2021. That is guided planning questions are fully completed and reflect the information on the participant record. The bar graphs shows that we are achieving about 70%.

These results have not quite reached the good range of 75 to 85%.

Question 2 – If there has been a change in guided planning, is there sufficient evidence to justify this change?

The light green bar graph shows the percentage compliance where guided planning questions are changed and whether there is sufficient evidence on the participant record to justify the change. The bar graphs show that we have crept up to 80% over

the last few months. This tells us that for about 20 of 100 approved plans, the evidence available in the participant record does not support the change to the guided planning questions.

These results have reached the good range of 75 to 85%.

Question 3 – Is the participant's level of function supported by appropriate evidence?

The dark orange bar graph shows whether the participant's level of function is supported by appropriate evidence. These bar graphs directly relate to the Update the WHODAS and the Update Severity Tools task – that the severity tool chosen is correct, the score is recorded correctly and information in in the severity tool is consistent across the participant record. The results show about 60% compliance, meaning that about 40 out of 100 plans for participants 7 years and older have a level of function recorded that is not supported by appropriate evidence.

These results have not reached the good range of 75 to 85%.

Question 4 – Has the primary disability been recorded correctly based on available evidence?

The dark green bar graph shows whether the primary disability is recorded correctly based on the available evidence. In the last CI Connect module about sustainability, we mentioned this result in relation to Rules for Participants 5.1b – supports are related to the participant's disability. The graphs show that we are consistently at about 90% compliance, indicating that about 10 of every 100 plans does not have a correct primary disability recorded.

This result is in the better range of 85 to 95%. There is opportunity for improvement to reach the best range for this question.

Further analysis of June data

Further analysis of the June data to explore whether compliance with the Update the WHODAS and Update Severity Tools task (Question 3) influenced KPI 5a - the % of plans where Section 34.1 of the NDIS Act is satisfied, demonstrated that:

- Correct completion of the Update the WHODAS or Update the Severity Tool task resulted in funding decisions that met Section 34.1 in 87% of plans – 5% above the national result for KPI 5a.
- Incorrect completion of the Update the WHODAS or Update the Severity Tool task resulted in funding decisions that met Section 34.1 only 74% of the time, well below the national result of 82% for KPI 5a in June 2021.

What does it mean?

It means that there is an opportunity to improve the Update the WHODAS and Update the Severity Tools task by:

- Paying closer attention to the chosen severity tool
- Carefully considering evidence
- Scoring and recording the tool correctly
- Substantiating and justifying all changes in an interaction - General - Update Severity Tools.

The data tells us that correct evidence based scoring in the Update Severity Tool task (and the WHODAS when appropriate) and the Update the Guided Planning Questions task results in better Reasonable and Necessary decision-making.

Better decision-making ensures a sustainable scheme now and into the future.

Severity Indicator – Video Transcript

See Appendix

Lesson 4 of 6

Overview - Video

A short introduction and overview of the use of the Severity Tools and their importance to the participant's journey and the planning process.

https://youtu.be/oZQfOzTwMsw

Resources - Things to read before the discussion

Lesson 5 of 6

Resources

The following resources examine the Severity tools in more detail and include SOPs and documents. of interest.
Complete the Update Severity Tools task
Complete the WHODAS
Complete the Guided Planning Questions

Tools

Cerebral Palsy Severity Tool: Gross Motor Functional Classification
Hearing Severity Tool:Functional Impact of Hearing Loss
Multiple Sclerosis Severity Tool:Patient Determined Disease Steps
Stroke Severity Tool:Modified Rankin Scale
Hearing Severity Tool:Functional Impact of Hearing Loss
Vision Severity Tool:Functional Impact of Vision Loss
Conversation Style Guide

Interaction Template

Interaction templates - General - Severity indicator updated, Request to change primary disability and Primary disability change complete.

Discussion and Examples

Lesson 6 of 6

Discussion Starter

Solution based questions for your team engagement session
Use any or all of the questions below to help facilitate the Severity Tool task Team Facilitation session.
You may decide to choose questions that you consider are more relevant to your team/State or Region.
You can choose to discuss questions as a whole group, in small groups, in partners or individually depending on the size of your team. Similarly, you can choose to use the same questions or designate different questions to groups to promote further discussion.
*Remember this session is an hour in duration and you need to allow time for a debrief.

Severity Indicator Discussion Questions.docx

Debrief and Next Steps

Debrief meetings allow you to formally conclude a discussion, identify key learnings and talk about next steps.
In concluding the team facilitation session, cover off expectations for weeks 2 - 4 as part of the CI Connect Program.

2. CI Connect – Severity Tools Knowledge Check

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Lesson 1 of 5

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What You Will Need

Lesson 2 of 5

Before you begin

- Take your time to answer the questions and refer to all available material via Intranet.
- The knowledge check is found in the next block. They are presented as true or false, multi choice, multi answer questions and match responses.
- You are required to correctly answer all questions to complete the module. You will be provided with a statement that your answer is either correct or incorrect. You must get a correct feedback statement on each question to proceed to the next question.
- Where you receive any incorrect feedback you will have the option to either review the module section or to take the question again. You can undertake the question as many times as you need until you get a correct feedback statement.

Knowledge Check- Severity Tools

Lesson 3 of 5

https://forms.office.com/Pages/ResponsePage.aspx?id=ZYt3zS11SkWHz7mZD-WJk3-inbY1Qx1Iti3MIgjtkndUQ01QREo5VjBST1JVRVo1SlJSWlZJVkRMRy4u

Click the button to go to a survey form. When you are finished return here to complete the rest of the knowledge check.

Knowledge Check

According to this module, which two of the five engagement principles are particularly important in the application of the content in this module?

Transparent & Respectful

Empowering & Connected

Respectful & Empowering

Responsive & Respectful

SUBMIT

TAKE AGAIN

According to this module, the Update the Severity Tools task is one of two Pre-Planning tasks that contribute to the generation of the Typical Support Package (TSP). The other task is...

Update the Guided Planning Questions

Update the WHODAS

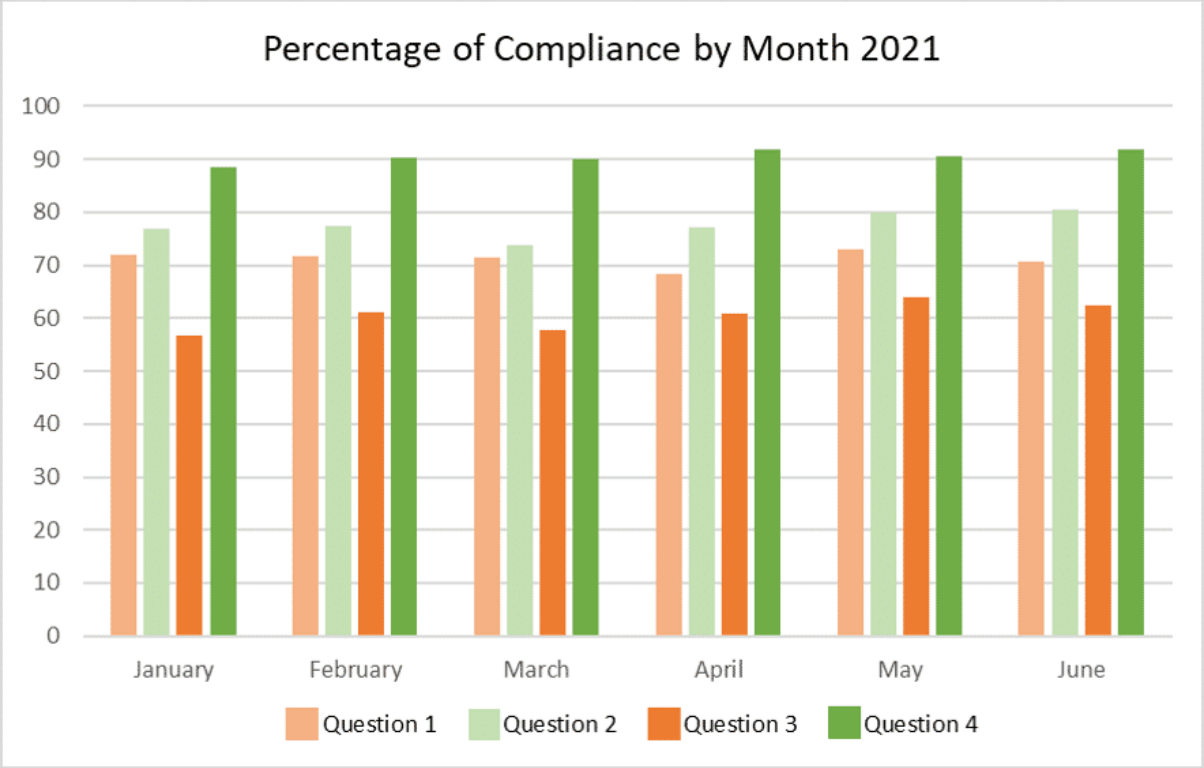
Update the Typical Support Package

Update the Percentage of Compliance

SUBMIT

TAKE AGAIN

Look at the following image



Which of these results have consistently reached the **good** range (ie. **not** the better or best range)

Question 1

Question 2

Question 3

Question 4

SUBMIT

TAKE AGAIN

The Standard Operating Procedure - Update the Severity Tools Task contains information about when plan developers are required to complete the Update the Severity Tools task. Here are some of the circumstances.

Which one of these is **not** one of the circumstances listed in the module?

The participant provides you with an updated functional capacity assessment

You are completing a plan review for a participant who is 0-6 years of age

The participant has a physical disability which has consistent outcomes over a period of time.

A severity score was not entered as part of the access process.

SUBMIT

General Survey

Lesson 4 of 5

Before you begin

Below is a general Survey about CI Connect.

- Take your time to answer the questions and think about your responses.
- The questions are multi choice, multi answer questions and free text responses. If you wish to change your responses then do so before clicking submit.
- There are no incorrect answers. Please be honest. The survey is anonymous.

Survey Link

Survey
Click this link to go to the survey

General Survey

Exit

Lesson 5 of 5

Course Completed.

Appendix

Video Transcript

The Update the Severity Tools task or Update the WHODAS task is one of the essential building blocks of planning and supports the integrity of funding decisions. Understanding the functional impact of disability and a participant's individual circumstances are integral to the way the NDIA approaches planning. The severity tool choice and scoring represents a participant's level of function. The scoring must be evidence based as it contributes to the Typical Support Package, guides decision-making and is the basis of the justification of funded supports included in a participant's plan.

For most participants the Update Severity Tools task is informed entirely by standardised functional assessments, scores and reports completed externally by a participant's treating health professional/s. They are submitted to the NDIA and attached to the participant's record.

These assessments constitute evidence for the planning process. The scores demonstrate the level of impact a participant's disability has on their everyday activities. Your conversation with a participant builds from these scores so that you fully understand what a participant can do and how they live their life.

When do you need to complete the Pre-Planning task Update Severity Tools?

The Standard Operating Procedure - Update the Severity Tools Task contains information about when plan developers are required to complete the Update the Severity Tools task. Here are the circumstances:

- There is a change in the participant's functional capacity
- The participant provides you with an updated functional capacity assessment
- You are completing a plan review for an adult or child who has met access based on disability or early intervention
- You are completing a plan review for a participant who is 0-6 years of age
- The participant has a degenerative disability such as motor neurone disease or an fluctuating disability like psychosocial disability where functional capacity may change

- A severity score was not entered as part of the access process.

Twelve of the most common disabilities and the NDIA preferred Severity Tool and a second or third option if the first severity tool option is not available is explained in the SOP - Update the Severity Tools task. It explains when to use the WHODAS and it outlines how to enter the score correctly in the NDIA Business System.

What is evidence?

Information taken from an external or internal assessment and recorded in the Update the Severity Tools task constitutes evidence. Severity Indicator information comes from three sources. In order of preference for plan development purposes these are:

- Disability specific assessments
- Internal disability specific Severity Tools
- Assessments not specific to a disability type.

Disability specific assessments:

- Treating health professionals complete these assessments
- Partner or NDIA staff **cannot** complete these assessments

Includes the Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5) for Intellectual Disability and Autism

Internal disability specific severity tools:

- Partner and Agency staff can complete these assessments

Includes the Gross Motor Function Classification Scale (GMFCS) for Cerebral Palsy, Modified Rankin Scale (mRS) for Stroke, Disease Steps for Multiple Sclerosis, Hearing and Vision tools

Assessments not specific to a disability type:

- Partner and Agency staff can complete these assessments

Includes the PEDI-CAT – Paediatric Evaluation of Disability Inventory Computer Adaptive Test and WHODAS 2.0 World Health Organisation Disability Assessment Schedule

When collecting functional capacity assessment information the score of an **external assessment** needs to be provided by the participant, their nominee, their child representative or their treating health professional.

Plan developers must:

- Sight a copy of the assessment report before the score is entered into the Update Severity Tools section of the NDIS Business System
- Attach the evidence in the NDIA Business System

Plan developers can complete the WHODAS assessment if an external functional capacity assessment is not available in the participant's record or if there is no other preferred NDIA severity tool.

What are the evidence requirements if there is no preferred external assessment tool and plan developers apply or change an internal disability specific severity tool? (This can include the WHODAS, PEDI-CAT, Gross Motor Function Classification Scale (GMFCS) for cerebral palsy, the Modified Rankin Scale for stroke, the Disease Steps for multiple sclerosis and hearing and vision tools)

There are four points for plan developers to note:

- You must sight evidence of the impact of a participant's disability or sight evidence of a change in function.
- Changes to severity scores must be justified in an Interaction General – Severity indicator updated
- Scoring information must be consistent across the participant record, including provider reports, Guided Planning Questions and the Planning Conversation Tool
- All evidence of function must be attached to the participant's record.

Evidence can be supplied in the form of a signed letter or a letter on formal letterhead from the participant's treating health professional. Evidence of the severity of the disability should include:

- type of disability
- date disability diagnosed
- how long the disability will last
- available treatments

- how the disability impacts the participant's everyday life. For example, mobility/movement skills, communication, social interaction, learning, self-care, self-management.

When competing the Update Severity Tools task or the Update the WHODAS task in Pre-Planning plan developers can ask themselves: Is the participant's level of function recorded in the severity tool supported by appropriate evidence? That is:

Is the chosen severity tool correct?

Is the score recorded correctly?

Is the information in in the severity tool consistent with other information in the participant record such as the Planning Conversation Tool, Guided Planning Questions, the Participant Statement or provider reports?

In addition, check that the primary disability is correct, that there is evidence attached to the participant record that confirms the primary disability (and secondary disability), that responses to the Guided Planning Questions are correct and that all information is consistent across the participant's record.

Pre-Planning tasks require careful attention to scores, evidence and participant information. They are the foundation of plan development. It is equally important that your information gathering conversation with a participant, their carer or nominee is dynamic and strength-based, uses open-ended and probing questions to focus on what the participant can do and how they live their day-to-day life.

This is quality Pre-Planning and leads to sound and sustainable funding decisions and a good participant experience.

CI Connect – Severity Tools: Team Facilitation Discussion Questions

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1. Improving Participant Experience

As a team, **how might we** prevent the issues outlined below affecting decision-making, sustainability and the participant's experience?

- The WHODAS has captured information related to conditions other than the eligible primary and secondary impairments.
- An Agency administered assessment was completed but the results are not consistent with other information about function in the participant's record.
- An internal disability specific severity tool was used and the score has been recorded incorrectly in the NDIA Business System
- The WHODAS has been used when a disability-specific assessment is available.
- An external assessment report does not match the score entered into the Severity Indicator tool.
- A child (0 -16 years of age) where a suitable functional capacity assessment is attached or referenced but has not been recorded, with only the PEDICAT completed.

2. Pre-Planning Update the Severity Tools Task

Let's start thinking about opportunities for improvement. Think about:

- Standard Operating Procedures and Tools
- Internal assessment tools to choose from
- How to use the internal assessment tools correctly
- The human element (operator error)
- How can we support each other to get this right?
- Innovations or enhancements

What might we change, modify or build to ensure that we complete this task correctly and that is it is evidence based?

- How do we ensure that scores entered or changed for internal severity tools can be justified by appropriate evidence? Where do you record your decision to change scores?
- When responses to guided planning questions are changed how can you ensure you have appropriate evidence to justify the change.
- When circumstances require a change to the Severity tool, what does 'sufficient evidence' look like in order to justify this change?
- If the Severity Tool has not been updated in line with the primary disability but rather in line with the associated impairments, what are the consequences for the participant? Section 34.1 a-f? Sustainability?
- What are the consequences for the participant when the WHODAS is used but a more specific assessment tool is more appropriate?