# Disability Support for Older Australians (DSOA) Individual Support Package (ISP)

## Client’s DSOA information

The DSOA Service Coordinator must email this completed and signed ISP along with the client’s most recent annual review outcome to dsoacompliance@health.gov.au and their Funding Arrangement Manager in the Community Grants Hub within 10 days of being updated and signed.

For more information, see [Appendix C: How to fill out the ISP template](https://www.health.gov.au/resources/publications/dsoa-program-manual-appendix-c-how-to-fill-out-the-isp-template?language=en).

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| --- | --- |
| **Client’s DSOA National ID:** | Click here to enter text. |
| **Client’s DSOA Service Coordinator is:** | **Organisation name:** | Click here to enter text. |
| **Office phone number:** | Click here to enter text. |
| **Client’s Case Manager (if applicable):**  | **Full name:** | Click here to enter text. |
| **Contact phone number:** | Click here to enter text. |
| **Email address:** | Click here to enter text. |

## ISP details

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| **DSOA ISP start date:***The ISP start date is the date the ISP has been signed by the client or the client's representative.* | Click to enter a date. |
| **DSOA ISP next review due date:***The ISP next review due date must be no more than 12 months after the ISP start date.* | Click to enter a date. |
| **What date was the client’s most recent annual review completed:** | Click to enter a date. |

## Information for the client about this ISP

* This ISP is an agreement between you and your DSOA Service Coordinator. It is a formal record of your DSOA funded package.
* Your DSOA Service Coordinator must review your ISP with you every year, or more frequently if required.
* They will contact you about your ISP review before the review due date.
* If you have any questions about your ISP, or if your circumstances change, please contact your DSOA Service Coordinator or Case Manager.
* You, your DSOA Service Coordinator and the Department of Health and Aged Care (the department) will have a copy of your ISP.
* The department will not disclose any information listed in your ISP to anyone else without your consent.
* The department will retain a copy of your ISP as a record that your DSOA Service Coordinator has shared the details of your DSOA funded package with you.

## Client's personal details

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| --- | --- |
| **Client’s full name:** | Click here to enter text. |
| **Date of birth:** | Click to enter a date. |
| **Home address:** | Click here to enter text. |
| **Home or mobile phone number:** | Click here to enter text. |
| **Email address:** | Click here to enter text. |
| **Preferred method of contact:** *Post, home phone, mobile or email* | Choose an item. |

## Client’s appointed guardian or carer contact details

|  |  |
| --- | --- |
| **Full name:** | Click here to enter text. |
| **Mobile number:** | Click here to enter text. |
| **Email address:** | Click here to enter text. |
| **Relationship to client:**  | Click here to enter text. |

## Client’s disabilities and health conditions

List details of the client’s primary and any secondary disabilities, as well as any health conditions.

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| --- | --- |
| **Primary disability** | Click here to enter text. |
| **Secondary disability** | Click here to enter text. |
| **Health conditions** | Click here to enter text. |

## Client’s living arrangements

List details of the client’s living arrangements (e.g., supported independent living, residential aged care, living in their own home or in a hostel, etc) and note how many other people the client lives with.

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| --- |
| Click here to enter text. |

## Client’s goals

List details of the client’s goals, including what the client wants to achieve using their DSOA funded support during this ISP period.

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| Click here to enter text. |

## Client’s disability support needs

List what tasks your client needs assistance to complete, and the level of support they need to complete these tasks (e.g., personal care, transfers, toileting, etc).

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| Click here to enter text. |

## Client’s current DSOA supports

List the DSOA funded supports the client currently receives, both on a weekly basis and less often (such as therapy or respite).

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| Click here to enter text. |

## Community access and/or activities the client participates in

List details of all community access activities the client participates in, including day programs. Note details of their frequency and duration, the support the client requires during these activities and how support worker hours are funded (e.g. through Extended CoS services or another Government program).

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| --- |
| Click here to enter text. |

## Client’s behaviour support

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| **Does the client display any behaviours of concern?** | Choose an item. |
| **Does the client have a Behaviour Support Plan (BSP) in place:** | Choose an item. |
| **Are there any restrictive practices listed in this BSP:***Any unauthorised restrictive practices are required to be reported to the NDIS Quality and Safeguards Commission.* | Choose an item. |
| **Date the BSP is due for the next review:*****If not applicable, write N/A.*** | Click to enter a date.  |

If the client has any restrictive practices listed in the BSP, please note below:

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| --- |
| Click here to enter text. |

Note: the department may request a copy of the client’s BSP at any time, including if a Change of Needs Application is submitted.

## Informal supports the client receives from family and/or friends

List details of any informal supports the client receives from family or friends, including the frequency of this informal support. For example, ‘I live with my brother who helps me to get to my medical appointments, as well as my personal care each evening after work’.

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| Click here to enter text. |

## Other sources of funding outside of DSOA

List any supports the client receives that are funded through other government programs. For example, Commonwealth Home Support Programme (CHSP) funded services (such as transport or domestic assistance), a Home Care Package, residential aged care, or equipment that is subsidised through a state/territory government equipment program.

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| Click here to enter text. |

## Client contributions

List any client contributions that your organisation has or intends to charge the client during the ISP period. This must be in accordance with what is allowed in your grant agreement and the DSOA program manual.

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| --- |
| Click here to enter text. |

## Client’s annual DSOA funded supports and services

This table should show the client their DSOA funding over a 12-month period. DSOA Service coordinators must update this table in consultation with the client anytime there is a change to the client’s DSOA funding amount, annual service outputs and/or DSOA support service types.

DSOA service coordinators should insert this information from their organisation’s Client Funding Breakdown (CFB).

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| --- | --- | --- | --- | --- | --- | --- |
| **DSOA Service Coordinator**  | **DSOA Support Service** | **Time of Day/Week** | **Output Unit** | **Annual Service Output** | **Hourly Rate**  | **Annual Amount** |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| **Grand total** | **$** |

## One-Off Change of Needs funding

The below section must only be used if one-off funding has been approved via a Change of Needs Application during this ISP funding period. All recurrent funding approved through a Change of Needs Application is to be listed in the above table.

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| --- | --- | --- | --- | --- | --- | --- |
| **DSOA Service Coordinator**  | **DSOA Support Service** | **Time of Day/Week** | **Output Unit** | **Output** | **Hourly Rate**  | **Annual Amount** |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
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| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| Enter text. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| **Grand total** | **$** |

## ISP agreement

The ISP must contain physical signatures or be signed electronically through a computer-based signature program (such as DocuSign) and include the full name of all signatories and date of signature.

If the client has a Public Guardian appointed, you must attach a letter from the Public Guardian agreeing with the ISP in place of a physical signature.

If the client has a Public Guardian appointed, you must attach a letter from the Public Guardian agreeing with the ISP in replace of a physical signature.

### Client’s agreement and signature

My DSOA service coordinator has explained my ISP to me, and I agree with what it says.

|  |  |
| --- | --- |
| **Client’s signature:** |  |
| **Client’s full name:**  | Click here to enter text. |
| **Date signed:** | Click to enter a date. |

### OR: Client’s appointed guardian or carer agreement and signature

*Guardian or carer details must be listed on page 2 of this ISP if they are a signatory.*

The DSOA service coordinator has explained this ISP to me, and as the client’s appointed guardian or carer, I agree with what it says.

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| **Client’s guardian or carer signature:** |  |
| **Full name of signatory:** | Click here to enter text. |
| **Date signed:** | Click to enter a date. |

### DSOA Service Coordinator agreement and signature

I have explained this ISP to the above signatory, I have provided this client and the client’s guardian or carer (if applicable) with a copy of this signed ISP for their records, I understand that this ISP will need to be reviewed and updated at a minimum every 12 months, or sooner if the client has a change in circumstance or a change in the client’s approved funding levels occurs.

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| --- | --- |
| **DSOA Service Coordinator signature:** |  |
| **DSOA Service Coordinator full name:** | Click here to enter text. |
| **Date signed:** | Click to enter a date.  |