# Disability Support for Older Australians (DSOA) Change of Needs Application Form

Please complete one form per client and email directly to: DSOAchangeofneed@health.gov.au

## Please read before completing this form:

* A Change of Needs Application **must** be submitted by the client’s DSOA Service Coordinator. The full legal entity (organisation) name of that DSOA Service Coordinator **must** be correctly listed in the application form at [Part A](#_Part_A_–).
* **Do not** disclose any personal information in this document or supporting evidence about National Disability Insurance Scheme (NDIS) clients who may reside in the same accommodation as your client.
* If your client has had a [My Aged Care assessment](https://www.myagedcare.gov.au/assessment) or is accessing aged care services (i.e., Commonwealth Home Support Programme). Please refer to the [DSOA Program Manual](https://www.health.gov.au/resources/publications/disability-support-for-older-australians-program-manual) to determine your client’s eligibility for additional funding through the Change of Needs process.
* You **should** refer to the [How to complete a change of needs application fact sheet](https://www.health.gov.au/resources/publications/disability-support-for-older-australians-program-how-to-complete-a-change-of-needs-application) for further information to assist you with completing a Change of Needs Application for your client.
* Incomplete applications **will not** be accepted. You will be advised the application form is incomplete and asked to resubmit. This will delay the assessment of an application, including the date from when funding will be considered.
* When a Change of Needs Application has been accepted and exceeds the $20k threshold or brings your client’s cumulative change of needs over the last 12 months to above $20k, the department will refer your client for an independent assessment (I-CAN). The department may also refer your client for an I-CAN assessment at its discretion to support the Change of Need Application. Please refer to the [DSOA Program Manual.](https://www.health.gov.au/resources/publications/disability-support-for-older-australians-program-manual?language=en)

## Eligibility and evidence:

* An application will only progress where it has been assessed as meeting the specific criteria (outlined in the [DSOA Program Manual](https://www.health.gov.au/resources/publications/disability-support-for-older-australians-program-manual)) and where funding is available.
* Your client must have experienced a change in need and/or circumstance, within the last 12 months, that relates to their disability. Any change in need that **does not** relate to the client’s disability is out-of-scope of the DSOA Program and **will not** be considered.
* You **must** submit evidence detailing how your client’s needs have changed and why your client requires additional support through the DSOA Program.
	+ Evidence to support a change in need may include mobility or occupational therapy assessment reports, letters from a General Practitioner, specialist, allied health practitioner, or hospital.
	+ The evidence provided must be within 12 months and **must** relate to your client’s change in their disability needs.
* You must submit your client’s completed up to date [Individual Support Package (ISP)](https://www.health.gov.au/resources/publications/dsoa-program-manual-appendix-d-individual-support-package-template?language=en) with each Change of Needs Application. The Change of Need Application will not be accepted if the ISP submitted is out of date or incomplete.
* You must submit evidence of your client’s annual review with your Change of Needs Application. The Change of Need Application will not be accepted if the annual review has not been completed in the last 12 months or is incomplete. Please see the [DSOA Program Manual](https://www.health.gov.au/resources/publications/disability-support-for-older-australians-program-manual) for more information.

Please submit your application, with all supporting evidence attached to DSOAchangeofneed@health.gov.au.

## Complete application checklist:

* A completed Change of Needs Application Form with responses against all questions.
* Signed Individual Support Package (ISP), no older than 12 months.
* Annual Review document, no older than 12 months.
* Evidence from a medical professional or relevant third party which documents the client’s change in circumstance/s.
* If *Assistance with Supported Independent Living* or *Assistance with Self-Care services* are requested, current and proposed Rosters of Care.
* Any additional documentation that is relevant to the client, application and circumstances relating to the client’s change in need.

## Part A – DSOA Service Coordinator Information

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| 1. | Organisation legal entity name*Refer to your grant agreement* | Click here to enter text. |
| 2. | Organisation ID number *Refer to your grant agreement* | Click here to enter text. |
| 3. | Schedule ID number*Refer to your grant agreement* | Click here to enter text. |
| 4. | State or territory | Choose an item. |

## Part B – Client Information

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| --- | --- | --- |
| 5. | DSOA National ID | Click here to enter text. |
| 6. | Client name | Click here to enter text. |
| 7. | Client’s current annual funding amount *As identified in your DSOA Client Funding Breakdown* | Click here to enter text. |
| 8. | Does your client have an underspend of their DSOA funding? | Choose an item. |
| 8.1 | If the answer is YES at Q8, what is the value of the underspend?*Underspend will be deducted* | Click here to enter text. |
| 9. | When was your client’s last annual review completed?*This must be within the last 12 months* | Click to enter a date. |
| 9.1 | Have you submitted a copy of your client’s annual review with this application?*A copy must be provided with your application* | Choose an item. |
| 10 | When was your client’s Individual Support Package (ISP) last reviewed?*This must be within the last 12 months* | Click to enter a date. |
| 10.1 | Have you submitted a copy of your client’s ISP with this application?*A copy must be provided with your application* | Choose an item. |
| 11. | Living arrangements*Refer to below definitions* | Choose an item. |
|  | *‘Residential’: If your client lives in Residential Supported Accommodation and you are applying for* [*Assistance in Supported Independent Living*](https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/supported-independent-living-provider-guidance/supported-independent-living-roster-care-submissions) *(SIL) in* [*Part C – Proposed Services*](#_Part_C_–)*, you must submit a current* [*NDIS SIL tool*](https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/supported-independent-living-provider-guidance/supported-independent-living-roster-care-submissions)*, showing the client’s current care, and a proposed SIL tool showing the additional services requested if funding is approved. Residents living with your client must be included (de-identified) in the NDIS SIL tool.* |
|  | *‘In-home’: If your client lives in their own home and you are applying for Assistance with Self-Care Activities in* [*Part C – Proposed Services*](#_Part_C_–)*, you must submit a current weekly care roster showing all staff supports the client currently receives and a proposed care roster of all staff supports the client will receive if funding is approved. The rosters can be in any format, if all 7 days are listed, including times of the day a support worker is with the client.* |
| 12. | Client’s primary disability  | Choose an item. |
| 13. | Client’s secondary disabilities *If applicable* | [ ]  Acquired Brain Injury[ ]  Neurological[ ]  Deafblind[ ]  Physical[ ]  Developmental Delay[ ]  Psychiatric[ ]  Hearing[ ]  Speech[ ]  Intellectual[ ]  Vision |
| 14. | Has your client previously had an aged care assessment or been approved for services under the *Aged Care Act 1997*? *If the answer is YES, see the* [*DSOA Program Manual*](https://www.health.gov.au/resources/publications/disability-support-for-older-australians-program-manual?language=en) *and check if the client meets the criteria to apply for additional funding.* | Choose an item. |
| 14.1 | If the answer is YES at Q14, when was the assessment and what was the outcome? | Click or tap here to enter text. |

## Part C – Proposed Services

* Please refer to the [Appendix A – DSOA Service and Pricing Schedule](https://www.health.gov.au/resources/publications/dsoa-program-manual-appendix-a-dsoa-service-and-pricing-schedule?language=en) when completing this section.
* Retrospective funding is out-of-scope of the DSOA Program. The funding commencement date for successful applications will reflect the date the completed application was accepted for processing.
* If the application is requesting recurrent additional supports, the request should reflect annual output and funding values.
* Only list the additional support you are requesting as part of this application in the table below. **Do not include any** **current funding** **the client already receives**.
* Quantity hours to be round up to the closest hour. For example: 15.7 hours is rounded up to 16 hours or 15.1 hours is rounded up to 16 hours.

| **DSOA Support Type** | **DSOA Support Level** | **Time of day / week** | **Is the Service recurrent or one-off?** | **(A)****Total outputs requested**  | **(B)****Unit Price** **(GST exclusive)** | **(A) X (B) =****Total funding** **(GST exclusive)** |
| --- | --- | --- | --- | --- | --- | --- |
| Choose an item.  | Choose an item. | Choose an item. | Choose an item. |  |  |  |
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| Choose an item. | Choose an item. | Choose an item. | Choose an item. |  |  |  |
| **TOTAL FUNDING REQUESTED:** | **$** |

\*Insert additional rows if required.

## Part D – Assessment Criteria

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| --- | --- | --- |
| 15. | What caused this change in need? | [ ]  Client's disability is deteriorating[ ]  Change to living arrangements [ ]  Unexpected event or accident[ ]  Change to informal support/carer arrangements [ ]  Other |
| 16. | How have your client's disability support needs and/ or circumstances changed? Change must have occurred within the last 12 months with supporting evidence attached. *Sufficient detail is required* |
|  | Click here to enter text.  |
| 17. | How will the additional supports requested specifically address the change in your client's disability support needs?*Sufficient detail is required* |
|  |  Click here to enter text. |
| 18. | When did your client’s disability support needs change? | Click to enter a date. |
| 19. | Is your client’s change in need permanent or a temporary change? | Choose an item. |
| 19.1 | If the change is temporary, when is it likely to end? | Click to enter a date. |
| 20. | Have other steps been taken to support your client’s change in need? | Choose an item. |
| 20.1 | If the answer is YES at Q20, provide details.  | Click here to enter text. |

## Part E – Declaration

You confirm that you, your organisation, and your submission have complied and will continue to comply with the terms of your organisation’s DSOA Funding Agreement as well as the additional conditions set out below.

1. You confirm that to the best of your knowledge, the information contained in your submission is true and accurate and that no other information that is relevant is known to you. Information that is relevant is that which may contradict or bring into doubt information given in the application or otherwise influence the DSOA Program’s consideration of the legitimacy of the services being requested or removed.
2. You will ensure that your submission or draft application does not include any personal information for the purposes of the Privacy Act 1988 *(Commonwealth)* other than the name of your organisation, contact details of the primary contact and other nominated contacts, clients IDs for your submission for which you have obtained consent to provide.
3. You confirm that:
* to the best of your knowledge, the information contained in your submission is true and accurate; and
* your submission complies with the 20 MB file size upload limit, and you understand that non-compliance with this limit may mean the department may not be able to accept your submission.
1. You accept and agree that you are responsible for any submissions made to the department by our organisation. The department is not liable or legally responsible for any of the submissions you make. Your organisation retains ownership of the application and its contents.

[ ]  **I accept the above declaration**

|  |  |
| --- | --- |
| Name  | Click here to enter text. |
| Position title in the organisation | Click here to enter text. |
| Date | Click to enter a date. |