# Service Request

*Once completed please email this form to care-requests@icare.nsw.gov.au and include the following in the subject header: Service Request [Person’s name and number] [icare contact name]*

## 1. Contact details

### 1.1. Person’s Details

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | | | Participant number or claim number | | |
|  | | | | |  | | |
| Address line 1 (street address, P.O Box, company, c/o) | | | | | | | |
|  | | | | | | | |
| Address line 2 (apartment, suite, unit, building, floor, etc.) | | | | | | | |
|  | | | | | | | |
| Suburb | | State | | | | Postal code | Country |
|  | |  | | | |  |  |
| Phone | | | Mobile | | | | |
|  | | | |  | | | |
| Contact name (if not injured person) | | | | | Contact phone | | |
|  | | | | |  | | |
| Date of injury | | | | | Age | | |
| Enter (DD/MM/YYYY) or select a date. | | | | |  | | |
| Injury | | | | | | | | |
| TBI | SCI Level: ASIA Score: | | | | | | Other (specify): | |

### 1.2. Service Requested by

|  |  |
| --- | --- |
| Name | Qualifications |
|  |  |
| Organisation | Work days / hrs |
|  |  |
| Phone | ABN details |
|  |  |
| Email | |
|  | |

### 1.3. Service Provided by

|  |  |
| --- | --- |
| Name | Qualifications |
|  |  |
| Organisation | Work days / hrs |
|  |  |
| Phone | ABN details |
|  |  |
| Email | |
|  | |

### 1.4. Status

*For interim status, services cannot extend beyond the interim participation period*

|  |  |
| --- | --- |
| Lifetime | Interim. Date of end of interim period: Enter (DD/MM/YYYY) or select date.. |

### 1.5. Service Dates

|  |  |  |
| --- | --- | --- |
| Does the person have a current My Plan? | | |
| Yes. What is the expiry date: Enter (DD/MM/YYYY) or select date. | | No |
| Dates for requested service. *(Note: Dates should not extend beyond plan expiry date).* | | |
| From: Enter (DD/MM/YYYY) or select date. | To: Enter (DD/MM/YYYY) or select date. | |

### 1.6. Attachments

|  |
| --- |
| Are any reports or other supporting documents attached to this service request? If so, please list below. |
| Yes  No |
|  |

## 2. What is the Person’s Current Status?

| 2.1. Current health conditions, impairments, activity limitations, or participation restrictions relevant to this request *(Include any non-injury related health conditions or impairments)* |
| --- |
|  |
| 2.2 Pre-injury information |
|  |

## 3. Requested Service

|  |
| --- |
| 3.1. What are the person’s goals that relate to this service request? |
|  |

|  |  |  |
| --- | --- | --- |
| No. | What new service is needed to achieve this goal? | What extra benefit will this bring to achieving the person’s goal? What steps are needed to have this? Who will be responsible for achieving these steps? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| 3.2. How is this service consistent with the goals and services in the person’s My Plan? |
|  |
| 3.3. What alternatives to the proposed service have been considered and discounted? |
|  |
| 3.4. How will the effectiveness of the proposed service be evaluated? |
|  |

## 4. Service Provider Declaration

I declare the person has been involved as much as possible in the development of this request in collaboration with their family member or nominated person if necessary. The person (and family member or nominated person) agrees with this request.

|  |  |  |
| --- | --- | --- |
| Name | Signature | Date |
|  | Signature | Enter (DD/MM/YYYY) or select date. |

## 5. Request for Approval

*List the requested services, service providers, payment codes, hours, and costs (including GST) including non-direct services such as provider travel.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Support to be requested from Lifetime Care or Workers Care  Select Code, if Flat Rate enter a description or leave blank & enter hourly rate and hours | Provider  (Include provider name, business name and business/invoicing ABN details) | Flat Rate Description  (ie AMA) | Hourly Rate or  Total Cost for Flat Rate Fees  (incl GST) | Number of hours and frequency | Cost (incl. GST) |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Total cost: | | | | |  |

|  |  |
| --- | --- |
|  | **icare** GPO Box 4052, Sydney NSW 2001 **General Phone Enquiries: 1300 738 586** Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) www.icare.nsw.gov.au |