# NDIS Service Agreement

***Please complete and email ALL pages to pqls@ch2.net.au or fax to 1300 766 241. The compulsory fields must be completed or they cannot be processed.***

*For any more assistance, please contact Customer Service on 1300 134 260*

|  |  |  |
| --- | --- | --- |
| **Provider Name:** | Clifford Hallam Healthcare Registration 4050000529 | |
| **Participant Name:** |  | |
| **NDIS Number:** |  | |
| **Who is arranging payment of your invoices?** | * Service provider   Refer to the core supports section on the NDIS plan. This will identify who is responsible for claiming from NDIS | |
| **Date of birth:** |  | |
| **Contact Person:** |  | |
| **Contact Number:** |  | |
| **Email Address:** |  | |
| **Delivery Address:** |  | |
| **Delivery Instructions:** | * Authorised to Leave * Signature Required * Other – please specify   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Planner Name:** |  | |
| **Planner Contact Number:** |  | |
| **Planner Email:** |  |  |
| **Plan Dates (DD/MM/YY):** | **From:** | **To:** |
| **Consumables Service Booking Amount:**  **(i.e. How much do you want Clifford Hallam healthcare to reserve for your goods)**  **If no amount is specified, $3,000 will be the default** |  | |

## Responsibilities of Provider

The Provider agrees to:

* Once agreed, provide supports that meet the Participant’s needs at the Participant’s preferred times.
* Communicate openly and honestly in a timely manner.
* Treat the Participant with courtesy and respect.
* Consult the Participant on decisions about how supports are provided.
* Listen to the Participant’s feedback and resolve problems quickly.
* Give the Participant the required notice if the Provider needs to end the Service Agreement.
* Protect the Participant’s privacy and confidential information.

## Responsibilities of [Participant / Participant’s representative]

* Inform the Provider about how they wish the supports to be delivered to meet the Participant’s needs.
* Give the Provider the required notice if the Participant needs to end the Service Agreement.
* Let the Provider know immediately if the Participant’s NDIS plan is suspended or replaced by a new NDIS plan or the Participant stops being a participant in the NDIS.
* To provide adequate information to the provider so a service booking can be made and funds claimed whilst remaining under budget.

## Payments

The Participant has nominated the NDIS to manage the funding for supports provided under this Service Agreement. After providing those supports, Clifford Hallam Heatlhcare will claim payment for those supports from the NDIS

If Clifford Hallam Healthcare is unable to claim the order amount from NDIS the participant will be liable for balance on the account.

## Agreement signatures

The Parties agree to the terms and conditions of this Service Agreement.

|  |  |  |  |  | |  |
| --- | --- | --- | --- | --- | --- | --- |
| Signature of [Participant/Participant’s representative] |  | Name of [Participant / Participant’s representative] | |  |
| Date |  |  | |
| Signature of authorised person from Provider |  | Name of authorised person from Provider | |

Date

## Attachment – Copy of Participant’s NDIS plan

[Attach a copy of the Participant’s NDIS plan if possible]