SUMMER FOUNDATION

FREQUENTLY ASKED QUESTIONS

For health services working with people with disability

This document is relevant for health services wanting to build the capacity of their staff around the NDIS and people with disability aged under 65. It contains frequently asked questions (FAQs) and answers relating to a number of different topics.

Health services may choose to download the Word version of this resource and add their own FAQs to maximise local relevance.

View frequently asked questions on the following topics by clicking on the links below.

Access

Are refugees or those who don't have Australian residency eligible for the NDIS?

To meet the residency requirements, you must live in Australia and be an Australian citizen OR hold a Permanent Visa OR hold a Protected Special Category Visa, that is, you were in Australia on a Special Category Visa on 26 February 2001 or had been in Australia for at least 12 months in the 2 years immediately before 26 February 2001 and you returned to Australia after that day.

Could a patient who is not a citizen or permanent resident of Australia apply to become either of these after being diagnosed with a permanent disability to become eligible for the NDIS?

The NDIS Act 2013 s.23-25 for eligibility to the NDIS states a person is required to be a citizen or permanent resident or meet special humanitarian visa requirements, as well as the eligibility requirements for access. The NDIS does not determine eligibility on timing of the disability, so if someone became a permanent resident after the onset of disability they are able to apply.

How are individuals with mental health issues catered for with the NDIS?

Support for all NDIS participants is based on the individual's eligibility as determined by the NDIS Act. Not everyone who has a mental health condition will have a psychosocial disability.

Why is it so difficult to get someone on the Autism spectrum approved for the NDIS when it affects so many areas of their lives?

The approach to supporting the person is around the functional impact on their life. The language and evidence about the functional impact is key - this is also the case for people with mental health conditions. ASD level 2 and 3 are listed on List A, so if a person has diagnosis of these levels they meet the NDIS criteria. List A conditions and access operations guidelines can be found on the NDIS website. As ASD is a spectrum disorder, some people with ASD will not have significant functional impact.

Are people with newly acquired neurological disability having any issues proving permanency of disability?

No, not necessarily. Getting the ARF right the first time and understanding how to articulate permanent and significant disability in NDIS language is important. Young people with non-progressive neuro disability may have difficulty if they request access too soon and potential for recovery may be questioned.

Can you apply for access before the patient's final disability can be quantified i.e. during the acute phase?

For individuals with progressive conditions or conditions that are not likely to improve according to evidence, you can start access requests early. However, this needs to be articulated well in the ARF. There is no need to 'wait' until a person has stopped improving. You can start the process as soon as it is known that the person will have a life-long disability. However, starting access requests early can be a problem for particularly young individuals with conditions such as stroke, which has some strong evidence for improvement, especially when compared to the level of disability someone might present with at the time of stroke. For these individuals, it's best to wait until it is known that the person will have a life-long permanent disability.

Does someone with a new disability need to be at their new baseline before being able to access the NDIS or can they discharge with expectations of further improvements gained at home?

No, patients do not have to be 'at their best' to request access. Requesting access should happen as soon as it's known that the person is likely to have a life-long permanent and significant disability. The exact severity of the disability does not need to be known. A permanent disability means it is likely to be with you for life. A significant disability affects your ability to take part in everyday activities. To receive funding from the NDIS, your disability must be both permanent and significant.

I have been told numerous times by the NDIS that a blank access form is not allowed to be emailed or provided to anyone other than the participant. How can I arrange for an ARF to be sent to the hospital?

A way to work through this would be to have the participant or their family member with you at the time access is requested. In this way, the person can state that they want their ARF to be sent to someone at the hospital. This is happening consistently throughout the country.

If a person is in the private system can they still access the NDIS for discharge planning?

The nature of the hospital (public or private) makes no difference to the person's eligibility for the NDIS, or the NDIA process used for their pathway - access, planning and implementation are identical regardless of the type of hospital.

If health services find it difficult to engage and communicate with the NDIA to provide the necessary supporting documentation in completing an access form for patients, how do individuals manage to do this in the community?

The NDIA funds "Partners in the Community" that are non-government organisations to assist people to understand the NDIS access process and develop plans.

What does the 'Complex Support Needs Pathway' do?

The Complex Support Needs Pathway involves a different pathway for selected participants with a single point of contact throughout, scheduled review/planning meeting/s and a conversation to discuss proposed supports prior to approval. Not all participants in hospital will be streamed into this pathway.

So, it is best not to make copies of the ARF to complete for new patients?

Yes, it's not a good idea to make copies. What other health services have done is created an electronic version of the ARF, that can be typed into, while awaiting the paper ARF to come through the post. Once the paper ARF arrives, with the number identifier attached, this can be sent back with the typed/printed version.

Some patients with severe debilitating lung disease have been deemed ineligible for the NDIS for basic support (personal care). Any advice for chronic lung disease patients (COPD/cystic fibrosis etc)?

Options include ensuring that the functional support needs of people with these conditions are clear - and that NDIS planners understand aspects to be funded via plans. A number of people have been made eligible once that is clarified.

What is the average time for eligibility to be established and planning completed for people with newly acquired disability? How is this time frame working for the hospitals?

The NDIS has a KPI of 21 days to respond to an ARF. However, the experience nationally is that it can take longer than that. The important thing is to get the ARF right the first time and provide all the necessary information. This will improve timeframes significantly. The timeframe for planning meetings also varies. Unfortunately, it can take several weeks for a planning meeting to be scheduled. Again, the most important thing health can do is be prepared for the planning meeting. This includes documentation of all supports, in NDIS language, with justification aligned with goals and the reasonable and necessary criteria.

What is the direct email contact mentioned for hospitals to request access?

nat@ndis.gov.au

What about patients who have a current disability but it is not clear if it will be permanent i.e. there is no organic cause, rather a functional presentation?

Obesity could be a good example of this. Unlikely to change but not permanent. It is important to consider other comorbidities which may enable access e.g. underlying mental health issues.

Does prognosis impact eligibility, e.g. oncology patients?

Prognosis can impact eligibility, but there are no black and white rules about this. Still consider the functional impact of the person's condition and how long this is likely to impact the person.

What about a bed-bound bariatric patient? Reversible, but disability due to early joint degeneration etc?

If the person is likely to experience long-term joint degeneration impacting their functional capacity, they are likely to be eligible. Endorsement from a specialist re the long-term nature of the impairment is still needed.

What about acute patients who are being discharged in 1-2 days and don't feel that they will be able to complete ARF paperwork on their own. Do we contact LAC?

If health teams can provide as much assistance as possible prior to discharge then the patient can seek further guidance from the Local Area Coordinator or their GP.

How are individuals with mental health issues catered for with the NDIS?

The NDIA is developing a 'complex pathway' for people with mental health disabilities, recognising the unique needs of these people. The NDIA is also understanding that mental health disabilities can change over time where a person's needs increase and decrease, reflecting this in plans. "Reimagine today" is a great website with good examples of the language you should use in access and preplanning documents.

I understand the NDIS likes examples in the ARF. What type of examples is it looking for?

Impact of disability on functionality – decision-making, personal care and domestic tasks.

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Advocacy

Who advocates/manages an NDIS package if the recipient does not have capacity?

Nominees will be appointed where requested by the participant or where necessary. If a guardianship arrangement is in place the presumption is that the guardian will be appointed the nominee. Nominees have a duty to ascertain the wishes of the participant and make decisions that maximise the personal and social wellbeing of the participant. Support coordinators funded through the NDIS are important for people with limited capacity/complex needs to bring their plan to life. A participant can also have the NDIA or a third party manage their plan financially, if they will struggle with this.

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Assistive Technology and Home Modifications

Can funds be accessed via SDA to modify a home to get a participant home from hospital then work on a secondary plan for a purpose-built home to best meet their needs?

Either SDA or home modifications are included as a pathway in a participant's NDIS plan. The pathway of SDA funding is for a home or dwelling only. The pathway for home modifications is funding in the Capital section of an NDIS plan. Find out more about SDA pathways and eligibility on the Summer Foundation website: https://www.summerfoundation.org.au/resources/sda-eligibility-criteria

Will the NDIS fund interim or transitional housing while home modifications are being completed?

No. The NDIS will not fund accommodation if a participant does not have SDA in their plan. Hire equipment and/or temporary modifications may be possible if deemed reasonable and necessary.

How can equipment for hospital discharge be arranged through the NDIS for patients who have significant needs but may not have yet met their full potential and will be referred for community rehab programs?

Equipment recommendations should be included in the pre-planning conversations with the person. If there is evidence that the person will need equipment to build their capacity, consider the hire line items included in the support catalogue to best meet their assistive technology needs.

If equipment is required for discharge i.e. hospital bed, wheelchairs, home mods etc does the AT form need to be submitted prior to the planning meeting or only at the planning meeting?

All assistive technology and home modification assessments and quotes should be sent directly to a participant's local NDIS office via email. Email addresses for local offices can be found here: https://www.ndis.gov.au/participants/home-equipment-and-supports/assistive-technology-explained/local-area-contacts-assistive-technology-and-home-modifications
Completing this process prior to the planning meeting is helpful to reduce waiting times for the participant after the plan has been approved, however this is not essential. It is helpful to have the purchase and/or hire quotes available at the planning meeting for the planner to include in the participant's plan. Please note that local processes in relation to AT for discharge may vary across different health services.

There are long delays for high cost equipment provision, which seem so unnecessary. Why?

This is probably as a result of the high demands on the NDIS as it is experiencing a high volume of on-boarding new and existing clients of disability services. You can regularly call the NDIS to seek escalation.

What options are available for a client requiring equipment for discharge but some items are not available for discharge via ELP (some transfer aids etc)?

Assistive technology items required for discharge that cost less than $1500 can be funded from the CORE consumables budget in a participant's plan and do not require an assessment and quote. This means that these items, such as a transfer aid (if less than $1500) can be purchased and do not require approval. For items that are more than $1500, with quotes and approval required, they can be hired in a participant's plan, in order to facilitate discharge from hospital.

A patient needs customised high cost equipment for discharge from an acute hospital. How do we come prepared to the planning meeting with the cost when we don't have the facilities and support to do equipment trials?

Determine AT level, and follow the pathway that is most appropriate for the participant. If this is not feasible within an acute setting, consider sub-acute, community health or private allied health options. If these are not an option and the participant remains in the acute hospital, consider arranging hire quotes to have available for the planning meeting (to be included in Capital Supports), and requesting adequate allied health assessment in Capacity Building Supports to trial the equipment in the community.

Does the NDIA take on board the advice of specialist units in relation to equipment selection?

The NDIA will accept assistive technology forms and recommendations from approved providers, such as an allied health practitioner, continence nurse, rehabilitation engineer, AT mentor or other suitably qualified practitioner. Further details on the AT assessment and recommendation process can be found here: https://www.ndis.gov.au/participants/home-equipment-and-supports/assistive-technology-explained

Is equipment maintenance, unscheduled repairs and equipment servicing included in NDIS plans?

Yes! But this needs to be discussed in the planning meeting. These items are only included when asked for. For this reason, preparing for a planning meeting is essential.

Would complex hearing aids come under capital - assistive technology?

Yes. Assistive technology for hearing is included under Capital Supports. Low cost hearing equipment can be included under consumables in Core Supports.

What can I do if I don’t agree with a decision that has been made about the AT we have prescribed for a participant?

The NDIA has processes in place for a planning decision to be reviewed. If a participant has support coordination hours in their NDIS plan it is helpful to use this to assist the decision review process. Further details on how to review a planning decision can be found on the NDIS website: https://www.ndis.gov.au/participants/how-review-planning-decision

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Health and NDIS responsibilities

Are there guidelines about what are health versus disability responsibilities?

In June 2019, the COAG Disability Reform Council met and agreed to some specifics around the health/disability interface - producing a fact sheet https://www.dss.gov.au/sites/default/files/documents/06_2019/attachment-drc-communique-fact-sheet-health-related-supports.pdf

Is there any more work around defining where rehabilitation ends and maintenance starts - in particular the impact of this on trying to determine who should provide supports/interface between health and the NDIS?

The COAG Principles document (https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf) describes some of this and the grey areas are often tested at the Administrative Appeals Tribunal.

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Implementation

How can I get a copy of a participant's plan?

The participant decides who to share their plan with. Providers are unable to share this information with other providers without explicit consent from the participant. Best practice is that the participant decides to share this. The recent Price Guide review recommended that once someone engages in a service agreement with a registered provider, that registered provider will be able to see their plan (or a version of their plan) on the MyPlace Portal.

What is an unregistered provider?

Not all providers choose to register. Unregistered providers can provide services that are fully funded by the NDIS. They can't claim their invoices directly with the NDIS, so if a participant wishes to use an unregistered provider, the person will need to either be self-managing that service or enlisting a plan management provider. Some health services have chosen to register as NDIS providers.

Who does the continence assessment for individuals that require continence aids?

A continence assessment should be done by someone with specialist knowledge in that area. An NDIA planner will decide which of the recommended aids are 'reasonable and necessary'.

How is the NDIS addressing emergency accommodation for people with changed needs, including behavioural escalation?

This is through "Short Term Accommodation & Assistance - STAA". The NDIA doesn't use the term respite. The NDIA Price Guide has information on what STAA is.

Will a plan manager's funding be allocated separately or will it be part of the NDIA allocated funding? If so, how much or what percentage?

Plan management is a funded service in a plan. The Price Guide has details on the funding amount. There are a few circumstances when the NDIA won't let the support be plan managed (e.g. equipment or some high risk items).

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NDIS language

OTs are skilled in assessing clients' functional skills. Unfortunately, most NDIS planners are not trained to understand the recommendations and clinical reasons. Why is not using NDIS language such a barrier rather than real clinical issues?

The NDIS has been established in goal orientated and capacity building language and is not a clinical model, so using the language of the scheme supports what the person needs in their plan.

Is there any more work around aiming to define where rehabilitation ends and maintenance starts? In particular the impact of this on trying to determine who should provide supports/interface between Health & NDIS.

COAG Principles document (https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf) describes some of this and the grey areas are often tested at the Administrative Appeals Tribunal.

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Preplanning

How many goals do plans generally include?

Recent plans we have seen have 2 short-term goals and 2 medium to long-term goals.

Would a 24-hour carer in a participant's home meet the "reasonable and necessary" test, or would the participant be directed to residential care?

We have evidence of people receiving 1:1 supports for 20+ hours living alone. It is important to provide evidence of a reduction of hours over time e.g. working towards active staff overnight becoming inactive.

Should participants have reached a discharge decision (home with modifications or SDA) prior to their planning conversation?

Yes, if possible. In some instances, this is not possible and the potential discharge options should be discussed in detail at the planning meeting. Health teams need to work closely with planners to determine what the NDIS will fund in terms of SDA, interim hire assistive technology and major home modifications. The decision about SDA is determined after the planning meeting, once all other options have been explored and the person meets criteria for SDA.

What is the best way to communicate with medical specialists and GPs to influence a broader style of report writing to demonstrate functional impact vs pure diagnosis?

The NDIA produced a GP and Allied Health Guide to the NDIS and there is an excellent resource produced by the Royal Australian College of Physicians for medical staff. The Summer Foundation also has a resource called "Getting the Language Right" available on our website.

With the NDIS is Centrelink still able to provide rental assistance or is this managed in a person's NDIS plan?

There is no change to any Commonwealth Rental Assistance for NDIS participants. They can still access CRA.

If a patient and their carers don't speak English can this be written into the plan for either specific language service providers or funded interpreters?

You do not need to put interpreter funding within a plan. You can access TIS interpreters with an NDIS participant number. Auslan is the only type of interpreting funded and it sits under core supports.

What is the background of NDIA planners?

NDIA planners have a range of backgrounds. Some have a clinical background (i.e. OT, SW), others have experience working in disability. Noting that the person needing the NDIS is in hospital with complex needs is a prompt to the NDIA to allocate a planner with the appropriate level of experience to address their needs. This may not always happen, but it will prompt the best possible response.

Do planners and Local Area Coordinators use a different preplanning document for the preplanning meeting or do we provide them with copy of preplanning tool/template?

Planners/LACs will have their own templates. However, any documentation health staff have developed with participants can be taken by the participant to the planning meeting (and/or forwarded to the NDIA prior), to support that process working effectively.

What are examples of health professionals using the wrong language?

Anecdotally, we have heard of difficulties with access and approval of supports in plans when information provided does not help the reader understand whether a person meets eligibility criteria; there is not enough detail about the impact of a person's disability and resulting impairment on participation in everyday life; there has not been clear justification against the NDIS reasonable and necessary criteria; or there has not been a clear link to an individual's stated goals.

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RAC

Is there a cap on how much a plan can cost?

The NDIS has no ceiling or plan cap - a person's plan is funded based on reasonable and necessary guidelines, considering value for money and lifetime costs.

What component of RAC fees can be paid by NDIS?

See the Summer Foundation resource "NDIS and Aged Care Fees".

Can you be a permanent RAC resident and access NDIS supports?

Absolutely. If a permanent aged care resident is assessed as eligible for the NDIS they can get NDIS supports. For examples of the kinds of supports they can get, see the sample plans on our website.

Do RAC fees reduce DSP? How are RAC fees for permanent versus temporary beds paid?

DSP and plans are separated. The paying of RAC fees via NDIS plans is complex (there are a range of 'fees', only some that are able to be funded through an NDIS plan, and some depend on how you elect to pay them), but is only available for permanent beds at this time.

What are the benefits of switching to the aged care system when a person turns 65? Surely the benefits under NDIS would be far greater?

It is a matter of choice, and some people prefer to work with the aged care system, particularly where their needs are primarily about ageing. It is unlikely at this stage that funding and support options will be greater through the aged care system than via the NDIS.

In your experience, are younger people being admitted from hospital to RAC that is specific to younger people or is it mainstream aged care?

Mostly mainstream aged care. There are a few aged care providers looking at developing something bespoke to young people (with mixed results/desirability) but often we are just seeing people in standard aged care.

Where a younger person with a disability has already entered permanent residential aged care and is not registered with NDIS, are they eligible to apply for and receive NDIS care to support their social, emotional and psychological needs?

Yes definitely. Back when the NDIS was in trial, the Summer Foundation undertook outreach work to ensure that young people in aged care knew that they could apply for supports and funding through the NDIS. Social, emotional and psychological needs could be addressed as part of the planning discussion and the goals identified. The NDIS took on the specific task of working with young people in RAC on a broader scale, but we know there are likely to be people still out there who may have fallen through the cracks. Typically the young person can receive funding for equipment (beyond the standard items aged care provides), support workers and transport funding to enable community access, support coordination and allied health support (generally but also to assist with searching for alternative housing options), as well as assistance with aged care fees. Details of the fees can be found at: https://www.summerfoundation.org.au/resources/rac-costs-for-ndis-participants/

Where a younger person with a disability who already has an NDIS plan enters permanent residential aged, at what age will their services (to support social, emotional and psychological needs) provided by the NDIS cease?

If a young person who is on the NDIS enters permanent residential care they can continue to receive NDIS supports. Once they turn 65, they can choose to remain with the NDIS or switch to the aged care system (for everything). The only time NDIS supports cease, as far as we are aware, is when an NDIS participant turns 65 then moves into residential care.

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Support Coordinators

Where or how do you find the right support coordinator?

All registered support coordination agencies are listed on the NDIS website. However, the skill base and experience of those providers is a matter of market competition. Experience with providers who have demonstrated capacity to work well with people with complex needs, those with ongoing clinical support needs and with concurrent health support needs, is the best indicator. Ultimately, under the NDIS, each individual has choice of provider but will often rely on word of mouth from a trusted source. Discharge planning staff will often be asked their opinion. Clickability.com.au is a website set up to provide peer reviews of NDIS providers and may be a useful source of information.

With regards to support coordination, would participants meet with a number of support coordinators to choose one before their planning meeting? Who pays the support coordinator to attend the planning meeting?

A participant must have Support Coordination identified in their plan to then be able to access it. There have been examples of support coordination agencies offering pre-planning support free of charge, and it is up to the participant whether the support coordinator attends the planning meeting.

Is there usually a wait list for clients to get a support coordinator?

As the market and NDIS continue to develop and grow there are still significant areas of growth required in the workforce to support people with disability - this includes the support coordination services. Local Area Coordinators (LAC) and the NDIS recommend that if a person waits longer than 2-3 weeks to have contact or have their support coordinator appointed, they should re-engage the NDIS planner or LAC to discuss/escalate service from the provider or pursue other options.

Have there been challenges involving support coordinators implementing plans while people are still inpatients e.g. equipment?

Yes, identifying skilled support coordinators and discussing the roles of the support coordinators and the health team as early as possible is important. As the role is new the collaboration between the health team and support coordinators is evolving. Support coordinators have a role in implementing the supports in the plan, no matter where the person is living. They have access to the plan and portal that health teams do not, and therefore can't support the participant with.

How can support coordinators coordinate supports if they don't understand disability?

Patients should choose support coordinators who have a good understanding of disability and supporting them to have opportunities through their funding to access employment or other social participation. It is helpful to work with the person prior to their planning meeting to identify a support coordinator likely to have skills and/or experience that will help them to better understand and support the person.

A patient who is already an NDIS participant comes into hospital and sustains further impairments affecting participation and limitation. How do we escalate to get the plan urgently reviewed when there's no more funding to increase supports?

A change of circumstance form needs to be completed and submitted, along with a request for an unscheduled plan review (i.e. you need to trigger a review - the change of circumstance is the evidence for urgency). Please refer to 'NDIS Readiness – a Toolkit for Hospitals" on the Summer Foundation website.

I have heard that 3 or 6-month initial plans can be requested for hospital discharge instead of the usual 12-month plan. Is this true? If so, what are the benefits?

There is growing recognition that short-term plans for people leaving hospital is a more effective way of ensuring good use of resources. However, each local area manages their own planning teams and variations on this response have been occurring.

Is the support coordinator hired by NDIA?

They are funded in the participant's NDIS plan and selected by the participant. They are paid like any other provider in the NDIS (i.e. through the participant, not directly by the NDIA).

Who makes a good support coordinator?

Support coordinators should be skilled and knowledgeable about local resources and service providers and should be able to link the participant and service providers through excellent communication skills in a person-centred way. Specialist support coordinators are required to be a professional, such as an occupational therapist, social worker or psychologist. There are no professional qualifications required for standard level support coordination, but these individuals, or the business they work for, are required to meet the quality and registration conditions of the NDIA. Feedback from participants is that attitude is their prime selection criteria. For people with high and complex needs, an understanding of clinical support needs and an ability to work across health and disability is important.

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Specialist Disability Accommodation (SDA)

Should participants have reached a discharge decision (home with modifications or SDA) before their planning conversation?

Yes, if possible. Sometimes this is not possible and the potential discharge options should be discussed in detail at the planning meeting. If a person is in hospital, their team can support the person in the planning meeting to demonstrate their need for hours for an OT and support coordinator to complete reports for SDA.

In terms of discharge planning - does the housing plan sit within the NDIS plan or are they separate processes?

The housing plan itself does not sit within the plan, however the hours required for a support coordinator and occupational therapist to complete the allied health report and housing plan sit within Capacity Building Supports of the NDIS plan. Check out the Sample Plan B, on this link for more information about how to include housing exploration supports in a plan.
https://www.summerfoundation.org/resources/sample-ndis-plans/

How does Supported Independent Living fit into SDA?

Supported Independent Living (SIL) supports are the direct supports to assist a participant to live day-to-day in their home and community environment. They are separate from the 'bricks and mortar' of housing, or SDA. SIL is usually describes when 2 or more people share their supports. Participants who live in SDA will have SIL supports and those who live in other types of non-SDA housing also may have SIL supports.
https://www.ndis.gov.au/providers/sil

Is a shared housing situation (owned by a disability provider) with all residents having a supported independent living quote called SDA?

Not automatically. If the disability provider is registered as an SDA provider and the housing is enrolled as SDA – then it is called SDA.

If a person needs supported accommodation, does this have to be secured before a plan can be finalised?

No. An NDIS participant does not need to have found an SDA dwelling before being determined by the NDIA for SDA funding (and for this to then be in their plan). Some people have successfully requested an interim plan (short term 3-month plan) in order to have funding to support the search for appropriate housing. The Summer Foundation has a sample interim NDIS plan on its website.

Who determines whether a property is accessible housing?

For housing to be enrolled as SDA, it has to be assessed and approved by an 'assessor' as meeting the criteria of the particular design category within the NDIA. This will determine its features and therefore accessibility. For non-SDA housing, it's up to listers to identify what is accessible about the property as there's no formal assessment required.

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