



Clinician webinar Q&A

NDIS and psychosocial disability

How many of the estimated total number of people living with severe and persistent mental illness are currently accessing the NDIS?

There are approximately 30,000 people with primary psychosocial disability in the NDIS now; this is the 3rd largest disability group, making up roughly 10% of all total scheme participants. NDIA have a great data page where you can explore this information in detail at <https://data.ndis.gov.au/explore-data/participant-data>

How are clients of former Commonwealth-funded mental health programs being supported to transition to the NDIS?

Clients who were part of PIR, PHAMS and Day to Day Living are being supported by the providers who used to deliver those programs to test their eligibility for the NDIS. They will support them to apply for the NDIS (including by helping together evidence), and to prepare for planning (if the person gains access to the NDIS) or to transition to continuity of support programs/other appropriate services (if the person doesn't gain access).

How do the principles of the NDIS align with recovery practices?

The NDIS planning and service delivery approach aligns well with the recovery orientated practices of the mental health sector, particularly the NDIS principles of choice and control, and person-centred care. It is necessary, when applying to the NDIS, for a person to identify areas of their life that they find difficult and for clinicians to provide a statement about the extent to which clinical recovery is likely. Whilst acknowledging difficulties that arise from mental health conditions is not contradictory to recovery approaches, it can be challenging for potential participants to do this, and the support of experienced recovery practitioners during the access phase can often be beneficial. You can look at our [Recovery and the NDIS training module](#) for more information.

NDIS and other systems

How does NDIS link with the DSP?

There is no link between the Disability Support Pension and the NDIS. A person does not need to be accessing the DSP to be able to gain access to the NDIS or vice versa. The eligibility criteria are different, so being eligible for the DSP does not mean a person will be eligible for the NDIS and vice versa. A person can receive both the DSP and NDIS support.



Is there an overlap between the therapy offered by mainstream mental health services and the allied health and therapy services under NDIS?

Therapies provided by mainstream services will be targeting the underlying mental health condition, therapies provided under the NDIS will be targeting the impacts of the mental impairments on the person's daily functioning. For more information on the responsibilities of the NDIS and mainstream health read the COAG agreement: <https://www.coag.gov.au/sites/default/files/communique/NDIS-Principles-to-Determine-Responsibilities-NDIS-and-Other-Service.pdf>

Can people use their NDIS plans for mental health treatments because our current system, which might only give people access to 10 visits, is sometimes not enough?

The treatment of mental health conditions is the responsibility of mainstream systems. Therefore, people cannot use their NDIS plans to pay for psychological treatments or therapies targeted at the underlying condition, even if the 10 visits funded under Better Access are not sufficient. Instead, there is a broader government focus on reforming the mental health support offerings for people with and without NDIS plans. More information is available on the Department of Health website.

People may, however, use their NDIS funding to access therapies delivered by a psychologist that are related to a specific goal in the person's plan and focus on capacity and skills building. To access these types of supports the person would need to have the appropriate funding in their plan.

How can the NDIS help people who may have had difficulties engaging with mainstream services in the past?

People can use their NDIS plan for support to engage with mainstream services depending on their goals and funding budgets. One option for people with psychosocial disability, when they are struggling to engage or navigate the different service systems, would be to involve a support coordinator to help build that person's capacity to navigate the systems more independently in the future. Or, if the person didn't feel comfortable going to appointments independently, perhaps a capacity building support worker could be funded to help with that process and build skills.

The NDIS also funds broader project work that builds the capacity of mainstream services to be more inclusive of people with a disability (including people who don't have an NDIS plan). These projects are funded through a grants scheme called the Information Linkages and Capacity building scheme (ILC) and you can read more about this on the NDIS website.

Access requirements for psychosocial disability – diagnosis and treatments

Does a person need to have a formal diagnosis of a mental health condition to access the NDIS?

It is not a requirement that the person have a formal diagnosis to access the NDIS, although it is helpful. If the person has a diagnosed mental health condition (confirmed by a qualified clinician using appropriate diagnostic assessments) then they can provide this information on the evidence of psychosocial disability form.



If there are conflicting symptoms that make it difficult to make a diagnosis, or definitive tests have not been completed, the clinician can instead state that the person has a 'mental health condition' and provide some information about how the condition presents.

How is permanency of mental illness assessed?

Impairments are considered to be permanent when there are no known, available and evidence-based treatments that would result in clinical recovery. Clinical recovery occurs when a person experiences significant improvement in symptoms and/or functional capacity. People for whom clinical recovery is likely are unlikely to meet NDIS access criteria.

People for whom ongoing or future treatments are focused on maintaining current function, preventing future decline in function or are focused on the person's personal recovery (e.g. working toward personal goals whilst living with the symptoms of mental illness) may still be eligible for the NDIS.

The NDIA assesses permanency based on information provided by the treating clinician(s) in part A of the Evidence of psychosocial disability form.

The treating clinician needs to provide their clinical rationale as to whether the person's impairments are likely to be permanent based on a review of the effectiveness of previous and current treatments and the likely success of future treatments.

Would a person with schizophrenia meet the access criteria?

It is helpful to focus on the impairments and resulting functional capacity rather than the diagnosis itself. Applying the criteria, if the impairments resulting from schizophrenia were unlikely to be clinically remedied, the person had tried appropriate evidence-based treatments, and is likely to experience significant and lifelong functional impairments in at least one of the six domains then they will meet the disability criteria.

If a person has PTSD after an assault and suffers from sporadic agoraphobia, would they be eligible?

As above, if the impairments resulting from the PTSD are likely to be lifelong (even when optimally treated) and have a substantial impact on the person's *daily* functioning, they are likely to meet the criteria. People who experience sporadic/episodic impairments, but who don't experience substantial daily difficulties in between episodes, are not likely to meet access criteria.

Furthermore, it is important to keep in mind that you do not need to share information with the NDIA regarding why or how a person came to have their disability. In this example, it would be sufficient to list the diagnosis as PTSD and describe the resulting impairments without detailing the trauma history that led to this diagnosis.

Can someone who has been diagnosed with non-curable cancer be eligible for the NDIS?

Palliative care services and cancer treatments/therapies are mainstream health system responsibilities and therefore not funded by the NDIS. Through the mainstream palliative care system the person would get the



type of psychosocial supports they need plus all the medical support. These services have a very holistic way of making sure that the remaining time is meaningful for that person.

If the person also had likely permanent functional impairments resulting from disability, which required daily supports beyond those provided by the palliative system, the person may be eligible for the NDIS.

Do you have any tips about putting an application in for someone who has Fetal Alcohol Syndrome? Is it recognised under the NDIS?

Fetal alcohol syndrome (FAS) is a List B condition. [List B](#) conditions are permanent conditions for which functional capacity will vary from one person to the next. This means that the NDIA recognise that the condition is likely to be permanent but need information about the extent to which the person is impacted by the condition (i.e the level of functional impairment) to determine if they meet the rest of the access criteria.

People with diagnosed fetal alcohol syndrome should provide their diagnosis and treatment history along with information about the extent to which they are impacted by their impairments on a daily basis. People with suspected (but undiagnosed) fetal alcohol syndrome/spectrum disorder can still apply and can contact the NDIA for more information about best evidence if it not clear from the person's treatment history. As with all conditions without a formal diagnosis, a clear description of the suspected condition, the resulting impairments (e.g. cognitive function), when they first presented and what interventions have been tried, is a good starting point.

What happens when there may be other treatments to remedy the impairments, but the person is not eligible (e.g. the treatments aren't publicly funded, are not suitable due to other health issues), or the treatments are experimental?

The NDIA need to see that an evidence-based treatment approach has been followed and that all reasonable treatments have been tried. The treating clinician is the one to determine the best-practice treatment approach for the person based on their knowledge of the condition, and of the individual. If the treatment plan varies from the standard approach, it is helpful to describe why (e.g. due to the nature of the person's impairments, a different treatment approach was tried). It is best not to point to gaps in the mainstream system as the reason for not taking a best-practice approach, as this indicates that the person's impairments may be remedied if they can access these services.

Many mental health conditions are associated with cognitive impairment. What is the role of neuropsychologists in commenting on impairment and on permanency in this regard?

Evidence from neuropsychologists can be very helpful for demonstrating likely permanent cognitive impairments and supporting an access request. Neuropsychology assessments may be most appropriate for people with conditions or injuries that directly impact a person's cognition, for example traumatic brain injuries/suspected brain damage or long term alcohol and other drug use (AOD). For AOD, neuropsychological assessments can help to demonstrate that impairments are likely to remain in the absence of drug and alcohol use. However, these assessments are not always accessible and should be considered on a case-by-case basis.



Some conditions are by definition chronic, enduring and hard to treat, and the treatment outcomes are difficult to predict. How can one comment on the recovery?

The NDIA need to be confident that clinical recovery is *unlikely* based on the clinical judgement of the treating clinician. Factors to consider when making this judgement include:

- how long the person has been experiencing mental health impairments
- how effective past treatments have been (and why)
- the possible outcomes of future treatments including the ‘best case’ scenarios and how likely it is that this can be achieved based on the person’s history/known efficacy of treatment options.

Remember, it is about the extent to which *clinical* recovery is likely. Consider whether the person is likely to improve to the extent that their impairments are no longer substantial or whether daily difficulties will remain, even when their symptoms are optimally treated.

If a person has a List A condition (e.g., moderate intellectual disability) the information they need to provide at access is less detailed and doesn’t discuss functional impact. Does this impact the suitability of their plan?

The decision about what to include in a person’s plan is made based on the planning meeting, rather than the information provided at access. When preparing for their planning meeting the person can reflect on their goals, their support needs and how their impairments impact their ability to meet these goals. This information (including any completed functional assessments if already available) can be brought to the planning meeting to help ensure plans are suitable. The NDIA representative at the planning meeting will also do their own assessment of the person’s functioning to better understand the daily impact of the impairments.

Can substance use be considered a mental health condition on its own?

While substance use disorder is acknowledged as a mental health condition the impairments and resulting treatments are likely to be mainstream responsibility and therefore unlikely to meet NDIS access criteria. Although, as always, this would vary from person to person depending on their condition(s) and history. People with substance use disorders, as for any condition, will need to show that the resulting impairments meet the five disability criteria, including that they are permanent and that the supports are best provided by the NDIS (and not provided by other systems).

Access requirements for psychosocial disability – functional capacity

It is interesting that economic inclusion is a big part of the aims of the scheme but it’s not its own separated domain of daily functioning. Is it included in the domains in some other way?

Economic inclusion is not its own domain of daily functioning; however, many of the other domains include components of daily life (e.g. socialising, managing schedules) that would ultimately impact a person’s capacity for economic participation. For example someone might be unable to leave the house independently which means they are unable to go out and apply for jobs or be around other people without support, which makes holding down a job and being economically independent unlikely. It’s a matter of breaking down that broader impact (economic participation) and considering which components of daily life contribute to that broader impact. Economic inclusion fits across many domains.



Accessing the community is a huge area for someone living with a psychosocial disability; why isn't this included in the mobility domain?

In the context of the NDIS, the mobility domain is about the use of limbs. For people with a psychosocial disability, you can certainly describe difficulties accessing the community, you just need to think about the *reason* for the difficulty and match that to the appropriate domain according to the NDIS definitions. For example, if a person struggles with community access due to extreme anxiety in public places, this would be an impairment in the social interaction domain, not the mobility domain.

Does an inability to use public transport fit within mobility?

As above, you need to consider *why* a person can't catch public transport. There are many reasons a person can struggle with public transport: they may have a learning difficulty that makes it difficult to use bus timetables, they may have social anxiety which makes it difficult to be in public spaces. Neither of these would fit into mobility but they could be explained in the learning or social interaction domains and achieve the same outcome.

Regarding mobility, what about psychomotor slowing that occurs with depression sometimes?

If the person experiences substantial difficulties using their limbs as a result of their underlying condition, then you should describe these difficulties in the mobility domain.

Is the trunk, neck and head included within the definition of mobility impairments?

If the issue with the trunk, neck and head affected the person's ability to move around, for example spinal cord injury you could put the impairment under mobility.

Can OT reports for NDIS, that cover functional aspects of the person's conditions, include other conditions such as ASD or intellectual disability as well as psychosocial issues? Or should the report follow the format of the EPD form?

Often OTs will have a format for providing functional assessments that is really holistic and may not trace the individual difficulties back to the different impairments. For access it is better if you can separate psychosocial from physical or other impairments. However, if you already have an assessment, it isn't advisable to pay an OT to re-write it so you may need to work with what you have. Perhaps in this scenario use the EPD form or a cover letter/support worker letter to expand on the assessment and clarify how it aligns with the access requirements. You also may not need to include the assessment if there is a completed LSP-16 as part of the EPD. In this case, save the OT report for planning discussions.

If you are an OT preparing a report specifically for NDIS access it is advisable to use the format of the EPD form (aligning difficulties to the six life domains) and making sure you separate the impact of psychosocial from other impairments.

What if the person doesn't have insight into their impairment or their function? What about when the person and their carer have different views?

This can be common for people with mental health conditions. The main thing to focus on is how to provide an accurate picture to the NDIA and work with the person to ensure they understand why this is required.



A carers statement can be helpful. It can state what the carer does for the person and what the person's day would look like without that support. The carer's statement is a good way to unpack that difference between what the applicant is saying and the reality of their support needs. If there is no carer, a support worker letter can help as well. If the carer statement is vastly different from the person's own statements, the support worker letter could describe why this is the case.

Secondly, the functional assessment tools can help to highlight a person's difficulties. The LSP-16 (included in the EPD form) can be completed without the person present if the worker knows the person well. There is also the proxy-rated version of the WHODAS [another functional assessment tool], which has been validated for scenarios like this. You could include the proxy WHODAS in combination with the participant rated WHODAS and then explain in the evidence for access, why you did the proxy version and why there is a difference.

Are cultural factors considered in assessment? For example, the ways that different cultures might experience psychosocial disability?

Yes, the NDIA will consider cultural factors in access assessments. People from other cultures may express things differently; the key is to frame how the person's mental health condition affects their day to day functioning in order to show the NDIA that there are substantial difficulties. If you can explain to the NDIA what the mental health impairment/condition looks like for this person and how this is relevant within their culture that is helpful. The NDIA are really open to accepting evidence in that format and when it comes to treatment, cultural treatment, they also will take that as well. For example, for Indigenous Australians, returning to country is considered to be one way to address mental health conditions – the NDIA will look at that as a legitimate treatment for an access request.

Access process for psychosocial disability – general

Does the Evidence of psychosocial disability replace section F of the Access Request Form?

Yes, the [Evidence of psychosocial disability form](#) can be completed in place of completing [part F of the ARF](#) and/or the [supporting evidence form](#) for people with a primary psychosocial disability.

Does the EPD have to be filled in in conjunction with the access request form (ARF), or is the EPD form alone enough?

The EPD form collects information to address the *disability criteria* but it does not include sections to address age, residency and consent which is also a requirement.

The person will also need to complete the ARF (leaving section F blank) or call the NDIA and do a verbal access request (VAR) to provide this additional information. Have a look at the ['how to apply'](#) section on our website which steps through it clearly.

If someone has two disabilities, you can fill out part F of the ARF or the supporting evidence form for their physical disability and the EPD for their psychosocial disability.

Sometimes when a person completes the VAR, the ARF or the supplementary evidence form is sent out automatically after the phone call. If that happens you don't need to complete them if the Evidence of psychosocial disability form is more appropriate.



How many times can a person apply to the NDIS? Is there a limit?

No there is no limit. A person can apply as many times as they like until they turn 65.

If a person is having multiple access not met decisions it might be best to have a think about what criteria is not being addressed and why NDIA are making that decision. Is it that they need to try a few more treatments before the condition can be deemed permanent? Or is it that the person isn't best supported by the NDIS? In that case it might be time to look at other support options that are available through the mainstream system.

If there are people that have put in earlier requests that have been denied, that may have been missing a bit of information, could they potentially apply again using the new forms and having more evidence to back up their claim? Should they refer to the previous information submitted?

Some applications that were submitted (for psychosocial disability) using the Access Request Form were unsuccessful because the generic form is designed for all disability types, and people didn't know what evidence to provide in a psychosocial context. We are seeing success when people re-apply using the Evidence of psychosocial disability form. However, it is important to remember that once evidence is submitted it stays on that person's file and is considered in the next application. If you think that evidence previously submitted might be misleading, outdated or contradictory, you may wish to address the reasons for this in a cover letter.

How can we support people who have significant and permanent disabilities that appear consistent with the criteria, but have been declined access by the NDIS, to ask for a review or to re-apply?

Encourage them to seek a review of the decision if it is within 3 months, or if it is longer, help them complete a new access request and use the EPD form. When a person is denied access, they will receive notification from the NDIA, and it will tell them what areas of the legislation they didn't meet. You can use this to look at the evidence that had been provided and see what additional evidence is needed to meet the access criteria. For example if a person was denied access because they did not meet the threshold for substantial impairment you know you will have to go back and review the description of how their day is impacted by their mental health condition when there are no supports in place.

If the application is too brief do the NDIS request more information, or will they just decline the application?

There is nothing wrong with a brief application if it is well written and includes evidence to address all the criteria. We've seen lots of examples of someone meeting access with just the EPD form and support worker letter, because the form has been designed to capture the information that the assessors need. Sometimes it is better to be brief because if you include lots of additional reports, chances are there will be some contradictory evidence in there, which means the access assessor will need to request more information.

In the past if there wasn't enough information, or contradictory information, the NDIA would have declined the request. However, we are increasingly seeing them go back to the applicant or health professionals and ask for more information. The important thing to remember is that, if you do not respond to the request for further information within the timeframes specified, the NDIS will cancel the access request.



Can people with other disabilities use the Evidence of psychosocial disability form?

It is better to use the EPD just for psychosocial disability and use the NDIA supporting evidence form or ARF part F for other disabilities. The EPD has been designed specifically for people with mental health conditions and includes the LSP-16 functional assessment tool which was validated for people with mental health conditions. For other disability types there would be more suitable functional assessment tools. Information on what functional assessment tools are best for each diagnosis can be found on the [NDIA website](#).

What are the NDIA doing to address the barrier that some people do not have the supports to help with access?

The NDIA have done a lot of work to look at how people who aren't connected to services or don't have those supports can be supported to access the scheme. From 1 July there will be an extension of supports through the [community connectors program](#). The connectors will work in metropolitan areas with groups that may be harder to engage, like people with psychosocial disability. These roles will focus on supporting people, largely with the access process, who are not connected with other services.

Also, if you are working with someone who requires support for access then you can refer them to [their Local Area Coordinator \(LAC\) office](#). LACs are funded to support people to gather evidence to put in an access request. The NDIA itself can assist over the phone if you are not in an area covered by an LAC.

Are there any external advocacy services to help someone if they need to challenge any of the NDIA decisions?

There are fully funded services that are listed on the [NDIA website](#). The Department of Social Services also have some listed on [their website](#) too.

What is the role of health and justice liaison officers? Can they help people to access the NDIS?

The health and justice liaison officers are specifically there to help people who are with in either of those systems. For example, if there is someone in hospital who requires support with discharge, then the hospital liaison officer will work one-on-one with the person to determine how they can be supported to put an access request in. If they are waiting for a plan, it's about what is happening for that individual person in the interim until the plan is implemented.

Can the applicant fill out the Evidence of psychosocial disability form?

The information required to complete the Evidence of psychosocial disability form is best provided by a clinician and other health professionals who have the qualifications to comment on daily function and likely permanency. If you do have somebody who wants to have input into their access application, you could ask them to write a participant statement about what their life looks like, and what they find difficult to do because of their mental health condition which could be included as an attachment to the form.

Access process for psychosocial disability – providing evidence

Who can complete the Evidence of psychosocial disability form?

The Evidence of psychosocial disability form has two parts, part A and Part B. Part A includes information about a person's diagnosis, the treatment history and efficacy, and the likely outcomes of future treatments.



Part B includes information about the person's daily function, what the impairments are, and which life areas are impacted by the person's impairments.

Part A should be completed by a treating clinician who has the qualifications and expertise to provide a clinical rationale about the likely permanence of the person's impairments, based on their assessment of the person's treatment history (therapy *and* medications) and their knowledge of the impairments. Generally, it is recommended that this be a [GP or a psychiatrist](#). If neither are available/suitable based on the individual's circumstances, other clinicians with similar qualifications and expertise (and access to medical records) are appropriate. This can include (but is not limited to) psychologists, clinical mental health nurses and nurse practitioners.

Part B should be completed by another health professional who knows the person well in a professional capacity and can provide information about their daily life and function. This includes (but is not limited to) support workers, psychologists, social workers and OTs.

What if the person has a lot of clinicians and providers who are involved in their care. How do you determine who should fill out the form?

The Evidence of psychosocial disability form is a way of gathering and *summarising* a person's history for the purposes of submitting an access request. The person taking the lead on the completion of the form will need access to information (for example, treatment reports) provided by other providers who are involved in the person's care and needs to be appropriately qualified to comment on this information.

A GP is often a good option for completing Part A of the form because they have access to medical records and are qualified to comment on diagnoses, treatments and outcomes. In this instance, other clinicians/specialists and providers can contribute to the request by providing information to the GP to summarise or by offering reports/letters as attachments to the form.

Use your knowledge of the person, their care team and the type of information required to determine who should complete the form and who can provide information/attachments to support the application.

Is it necessary to have both the clinician and another health professional (support worker, allied health) complete the Evidence of psychosocial disability form? Can the treating clinician complete the whole form if another health professional is not available/suitable?

If the treating clinician/GP knows the person well and is aware of what an average day looks like for the person they can fill out both sections. This will involve writing about how the person functions within the relevant life domains as a result of their mental health impairments and providing examples. Often the clinician may not be best placed to provide the functional information as their focus is on the treatment of the mental health condition rather than the daily impact of the condition. In these instances, it is advisable to see if there is another person who can contribute to the request; in multidisciplinary teams this might be a psychologist, social worker or other disability support worker.

Can a psychologist complete the Evidence of psychosocial disability form as the primary treating clinician ?

As discussed above, the primary treating clinician will need oversight of the person's treatment history including both psychological and pharmacological treatments. The guidance from the NDIA is that this information is best provided by GPs or psychiatrists. However, there may be circumstances where a



psychologist or other clinician is a more appropriate choice (see above). If it is most appropriate based on the person's circumstances and service engagement, then yes, a psychologist can lead the completion of the form.

Remember, psychologists still play a critical role in providing evidence for an access request even if they are not the treating clinician for the purposes of completing the form. Psychologists can provide information in part B of the form, can prepare supporting clinical information as form attachments, or provide treatment summaries to support the clinician who is filling out the form.

Are psychologists seen as appropriate to provide diagnosis for clinical evidence?

The Evidence of psychosocial disability form asks for information about the person's diagnosis or diagnoses and when these were made. It is appropriate for these diagnoses to have been made by a psychologist.

Can a nurse practitioner complete the Evidence of psychosocial disability form as the primary treating clinician?

If the main treating clinician is a nurse practitioner (as per the above information) they will be well placed to complete the treatment parts of Section A of the form. As discussed previously, it is important to consider who is involved in the person's care team when determining who completes the form and who provides supporting information.

Can a GP complete the diagnosis that has been confirmed in a letter to the GP from the psychiatrist?

Yes, the GP can complete the diagnosis based on information provided by other practitioners – they should state who made the diagnosis and when the diagnosis was made.

Providing evidence

Are there resources to help clinicians to write their supporting documentation. e.g., OT reports to align with the format NDIS accepts – are there any templates or proformas?

We have lots of resources and templates on [our website](#). Depending on the person, a well completed Evidence of psychosocial disability form and a letter from a support worker can be sufficient. Have a look at the 'streamlined access process' on our website, and our guide to writing a great support letter, and support worker letter template.

How are clinicians remunerated for the time spent providing evidence for an access request?

There is no specific funding for the completion of forms/reports for NDIS access. Clinicians who can charge for their services under Medicare should select the [most appropriate MBS item based on the nature of the consultation](#).

To claim through the MBS you must do the NDIS access paperwork as part of a clinical consultation and the applicant must be present. Ideally, a double appointment should be booked as you will need to have a conversation with the person about their mental health condition and what information needs to be provided for that application.



In terms of gap payments/private billing for the purposes of providing information for access – it is a business decision for the clinician and their practice about how they charge for these services. The Evidence of psychosocial disability form has been specifically developed to reduce the time spent by clinicians in preparing reports and evidence for access.

Clinicians often do not have time to complete the paperwork to support someone's access request. Are there any tips on how to reduce the burden of paperwork?

Time is one of the greatest issues affecting busy GPs and that is actually one of the reasons why the Transition Support Project worked with the NDIA to develop the Evidence of psychosocial disability form. The form specifically addresses the fact that GPs and other clinicians are very busy and minimises the amount of information to be provided.

Much of the information in part A (medication lists, diagnoses, hospitalisation dates) can be completed by other members of staff if the form is provided to the practice in advance of the scheduled appointment. At the consultation, the clinician can review the information with the applicant, complete the permanency statement and sign the form. They can also review the functional information provided by the person completing Part B and endorse this information without needing to provide extra detail unless they choose to.

NDIS plans

Is there a time limit to schedule the planning meeting once a person has met access?

There is no set time frame or limit. Once someone has had an access met decision, they will be contacted to arrange a planning meeting. This is normally within a few weeks. The person can ask for a different date if they need more time, but they may have to wait until the planner or LAC has capacity.

If an NDIS participant is doing really well with their plan are they at risk of getting a 'worse' plan in the subsequent 12 months?

The funding for each plan is determined by applying the reasonable and necessary criteria. This includes an understanding of the person's current functioning, the capacity of their support networks, their goals, and their service needs. If someone has functioned well in their first plan because of good support networks, explain this at plan review and justify the supports needed to achieve goals for the next plan. We have a [plan reviews training module](#) on our website.

Has there been a change in the criteria for support coordination for people with a psychosocial disability? In the last 6 months it has been harder to get, and people are using their core funds to fund this.

All NDIS funded supports are based on the reasonable and necessary criteria. It is important to demonstrate the need for support coordination, taking these criteria into consideration. We have a support coordination training module and factsheet on our website – we recommend taking a look at those for more information. <https://www.tspforall.com.au/resources>



One of the difficulties for GPs is that while they are expected to fill in the application form, they are not included in the planning stages nor are they given copies of the patients plan, so they are at a bit of a loss as to what is provided by the NDIS and what they need to source from other areas to help their patients.

There is a gap between a person meeting access and having their planning meeting. This time is referred to as the 'pre-planning' phase and is a great opportunity to gather information from health professionals about what types of supports are required in a plan. Alternatively, the GP may provide this information at the time of discussing the access request (as a separate document, ideally not to be submitted with the access evidence) and the person can keep this information for use at planning. Furthermore, the person is welcome to bring other health professionals to their planning meeting with them if suitable (although it is acknowledged that this would be difficult for GPs). A support worker who knows the person well, and may have attended GP appointments with the person, could share information on the GPs behalf.

The NDIA have strict measures in place to protect the privacy of participants and won't automatically share the person's plan with other health professionals. However, you can speak to the patient about [getting consent to view their plan](#), or the patient can email/print a copy for you.

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