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**Service Agreement**

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ABOUT THIS AGREEMENT

This Service Agreement is made for the purpose of providing an agreement for supports for NDIS (National Disability Insurance Scheme) Participants.

This agreement will be used for every person who receives supports from Decent Care. People who want support will be asked to sign the agreement (where practicable) and a Decent Care authorized representative will also sign it. If you are not able to sign, a Plan Nominee may also do this, with your consent. A note will be made on your file to explain why this has been done.

The welcome pack explains what you can expect from Decent Care and what your responsibilities are when you receive support from us.

We will talk with you about the type of support you are looking for and what we can offer you at Decent Care to meet your needs. Before you start receiving support we will explain and talk about this agreement with you and anyone else you tell us you would like to know about it.

Once the agreement has been signed, we will keep the original agreement at Decent Care and give a copy to you and anyone else you would like to receive a copy.

WHO IS MAKING THIS AGREEMENT?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Icon  Description automatically generated | The name of the participant or their trusted person: | | | | |
| Participant Name | | |  |  |
| **NDIS no**: NDIS Number | | | | |
|  | The name of the service provider: | | | | |
| **Decent Care Pty Ltd** | | |  |  |
|  |  | |
| This Service Agreement is ongoing from: | | Service Start. | to | Service End | |
| NDIS Plan start date and end date | | Plan Start | to | Plan End | |

WHAT SUPPORT WILL BE PROVIDED

| Item Number | Item Name and Notes | Unit | National |
| --- | --- | --- | --- |
| **07\_101\_0106\_6\_3** | * **Psychosocial Recovery Coaching** | **Hour** | **$93.34** |

Decent Care will provide support coordination as per the plan of HOURS hours per month

( HOURS PER MONTH hours per annum) total of $ TOTAL OF Decent Care will provide an outcome report.

The costs for this service are in line with the NDIS Price Guide. Decent Care will provide support and services as per the plan.

**Decent Care will confirm the delivery of support with** PARTICIPANT NAME **and then claim the payment directly from NDIS.**

ENDING THIS AGREEMENT

Should either Party wishes to end this Service Agreement they must give a minimum of fourteen (14) days’ notice or less if agreed by both parties. If you would like to end it sooner than fourteen (14) days, Decent Care will support you to do so.

sooner than fourteen (14) days, Decent Care will support you to do so.

CONTACT DETAILS

**Participants can be contacted on:**

|  |  |
| --- | --- |
| **CONTACT NAME** | PARTCIPANT NAME |
| **PHONE OR MOBILE** | PARTICIPANT CONTACT NUMBER |
| **DATE OF BIRTH** | PARTICIPANT DATE OF BIRTH. |
| **EMAIL** | PARTICIPANT EMAIL |
| **ADDRESS** | PARTICIPANT ADDRESS |
| **EMERGENCY CONTACT PERSON** | EMERGENCY CONTACT PERSON |
| **EMERGENCY CONTACT NUMBER** | EMERGENCY PERSON CONTACT NUMBER |
| **EMERGENCY CONTACT EMAIL** | EMERGENCY PERSON’S EMAIL |
| **RELATIONSHIP TO THE PARTICIPANT** | RELATIONSHIP TO THE PARTICIPANT |

**Decent Care can be contacted on:**

|  |  |
| --- | --- |
| **CONTACT** | Decent Care Team |
| **OFFICE NUMBER** | 03 3706 7619 |
| **EMAIL** | enquiries@decentcare.com.au |
| **ADDRESS** | 41 Hartnett Drive, Seaford VIC 3198 |

AGREEMENT

If you are the person who is receiving support from Decent Care, and you understand this agreement, please sign in Execution Clause Number One Below.

By signing this Agreement, you agree to all of the information included.

Top of Form

|  |  |  |
| --- | --- | --- |
| **Participant name:** | | PARTICIPANT NAME |
|  |  |  |
|  | Date: | DATE OF AGREEMENT |

Bottom of Form

|  |  |  |
| --- | --- | --- |
| **Service provider name:** | | Decent Care Pty Ltd |
|  | Signature: |  |
|  | Date: | DATE OF AGREEMENT |

*[If you are signing this agreement on behalf of a child (under the age of 18) or an adult with impaired decision-making capacity, then please indicate your relationship to the person who will be receiving support from Decent Care.]*

Top of Form

|  |  |  |
| --- | --- | --- |
| **Participant’s Trusted Person name & relationship:** | | NAME OF PARTCIPANT’S TRUSTED PERSON |
|  | Signature: |  |
|  | Date: | DATE OF AGREEMENT |

Bottom of Form