FAQs GPs and other health professionals ask about applying for access.

How can my patient apply to access the NDIS?

Patients and/or carers can make an access request by:

- contacting their local area coordination or early childhood partner if they or you think they are eligible.
- calling 1800 800 110 if they are in an area where there is no local area coordination or early childhood partner
- visiting their local NDIS office
- downloading the Access Request Form pre-completing the access information and emailing it to enquiries@ndis.gov.au along with any supporting information. Pre-completing this form will support the local NDIS partner to work with the applicant and finish the request.

The application will only be progressed once the patient also submits adequate evidence detailing their impairment and its functional impact (e.g. copies of existing reports, letters and/or assessments from treating professionals, support workers, family members and carers).

Find out how long this takes in our Participant Service Guarantee.

Do I, as the patient's treating professional, have to fill out any part of the Access Request Form?

Your role as the treating professional is to provide objective evidence that the patient has a permanent impairment that results in substantially reduced functional capacity in one or more of the following areas: mobility, communication, social interaction, self-management, learning and self-care.

You can provide this information by:

- completing the 'Treating Professional' section of the Access Request Form (Part F of the current Access Request Form); and/or
- attaching relevant reports, letters and/or assessments from one or more treating professionals, if you feel this information is already adequately detailed elsewhere. This may include preparing your own letter/report to
  - (i) clearly articulate the diagnosis (i.e. nature of the impairment resulting in disability) and likely permanence, and

○ (ii) outline its functional impact and the types of support required.

In this case, you should clearly mark on the Access Request Form that an Evidence of Psychosocial Disability Form is attached.

As a GP, you need to decide if you are the right treating professional to be providing this information.

If you do not have enough information on file or you don't fully understand the functional impact of a patient's impairment, you may need to reach out to other treating professionals (e.g. specialist doctor, allied health professional) for copies of existing reports, letters and/or assessments.

Alternatively, if you believe another treating professional is better placed to articulate the functional impact of the patient's impairment and the types of support required, you may choose to refer the patient on to this professional for the support they need to access the NDIS.

Requesting costly new assessments from allied health professionals or other specialists is not required if sufficient evidence of impairment and its functional impact already exists.

What evidence validates the person's impairment?

Treating professionals are required to provide the following information:

- name of medical condition and resulting impairment
- date of diagnosis and how long your patient's functional capacity has been affected by the impairment
- indicate if the condition is terminal or degenerative in nature.

You should also attach any existing evidence from the patient's file that confirms the diagnosis (a letter of diagnosis is often the best way to provide evidence of an impairment).

If the patient has more than one disability, you only need to provide this information for their 'primary disability', i.e. the disability with the greatest functional impact day-to-day.

However, you should list any other (secondary) disabilities that also impact their day-to-day function.

What information best demonstrates an impairment's permanency?

For the purposes of the NDIS, an impairment is permanent if it has not been, and is unlikely to be, substantially alleviated by conventional treatments.

Therefore, in your response, it is important to summarise a patient's treatment journey to date, i.e. list past and current treatment, along with duration/frequency and treatment response/outcomes.

Future treatment options and the patient's likely response to them should also be explained.

Not having tried all conventional treatments does not automatically preclude a patient from joining the NDIS. If any available treatments have been deemed unsuitable for your patient, attach your clinical rationale to the form.

Do I need to fill out every functional domain on the Access Request Form?

The six NDIS functional domains (mobility, communication, social interaction, self-management, learning and self-care) aim to capture how a disability impacts upon all aspects of a patient's life.

They provide a practical and holistic framework within which to contextualise a person's disability and to understand the type and level of support an individual requires to live well.

When filling out this section of the Access Request Form, you only need to complete the domains which are significantly impacted by the patient's impairment.

For example, the patient may have substantially reduced function when completing mobility and self-care activities. However, the other domains may be unaffected or only minimally affected.

What type of information best helps to describe a patient's 'functional capacity'?

The NDIS assessor requires relevant and objective evidence that the patient's impairment has resulted in substantially reduced functional capacity in one or more of the following areas: mobility, communication, social interaction, self-management, learning and self-care.

For each affected life area ('functional domain'), describe in simple terms:

- what the patient cannot do without support due to their impairment (provide clear examples);
- how this impacts their day-to-day function, employment and/or interaction with peers and the wider community;
- what supports are already being received (from family/carers, services and community) and how the patient has or has not benefitted;

- the type and intensity/frequency of supports needed and how they will build functional capacity and/or halt the progression of the impairment; and
- how these supports will improve social and economic participation.

When completing your response, it is important to remain focused on describing the impairment and its impact, not just the medical condition which led to the impairment.

For example, simply stating that the patient had a below-knee amputation due to vascular complications from Type 2 diabetes does not provide sufficient detail for the assessor.

In this instance, it's also important to state that this physical impairment has led to unstable mobility, so they need help showering, shopping, etc.

If your patient has a List A condition, you do not need to provide information about functional status unless specifically requested. However, evidence related to diagnosis and treatment is still required.

How can I gain a better understanding of how my patient's day-to-day function is affected by their impairment?

If you don't have a good understanding of how a patient's day-to-day function has been affected by their impairment, you may need to have this conversation with the patient and/or their carer as part of a longer consultation.

Having them run you through a typical day in their life, while outlining the challenges they experience and the different kinds of help they require to complete ordinary tasks of daily living (e.g. dressing, preparing a meal, getting groceries) is a good place to start.

You will also want to explore with them how their ability to work, socialise and participate in community life is affected.

This 1:1 discussion can be a particularly effective approach for identifying other areas in which a patient could benefit from disability supports – in addition to the types of support that initially motivated the patient/carer to seek NDIS access.

This conversation may also help the patient or carer to open up about functional issues they are sensitive about or reluctant to disclose.

Within the primary care environment, practice nurses can be a useful resource for eliciting this information for you.

For example, by meeting with the patient and/or carer first, the practice nurse can gain a more detailed understanding of the day-to-day challenges faced by the patient as a result of their

impairment.

They can then document these insights and help you identify what practical supports are required. Practice nurses can also assist you to request/collate existing evidence from other professionals, e.g. assessments, reports.

> **Why does the NDIA want me to describe the type and frequency of assistance (disability supports) required? Isn't that the role of the NDIA planner?**

This information helps confirm the patient's eligibility for the Scheme.

It also facilitates the subsequent planning process by providing a starting point for discussions between the NDIA planner and patient about the types and level of support required on a daily basis.

Common types of support that may be required include:

Examples of support

Mobility and motor skills	Communication	Social interaction	Learning	Self-care	Self-management
• Using public transport • Leaving the house • Moving around house • Going to shops • Modifications to house • Other	• Letting other people know needs and wants • Help to talk wth others • Assistive technology • Following instructions or directions • Other	• Initiating conversations • Social interaction • Making and keeping friends • Understanding feelings and interactions • Talking to strangers or particular people • Other	• Learning new things • Organising information • Memory and planning • Studying and attending courses • Other	• Looking after self • Personal hygiene • Shower, dressing • Dental/oral hygiene • Medication • Other	• Doing household jobs • Budgeting money • Problem solving things that arise • Making decisions • Keeping safe • Taking responsibility • Looking after nutrition and diet • Other

What type of language should I use when providing evidence?

Where possible, avoid using clinical or medical terminology. Use plain English and frame your responses in terms of what activity limitations the patient experiences day-to-day due to their impairment.

A gold standard example is shown below:

EXAMPLE (Functional Domain: Learning)

Kris has difficulty understanding and remembering information and then translating that into actions or tasks. He is unable to learn and remember the tasks associated with going shopping by himself, or cooking, or being able to predict what is going to happen next and organise information in a logical way to make his decisions. Kris is unable to be left alone within his home or the community as he needs supervision constantly to ensure his safety in all these environments. He requires a support person to be with him to assist him to understand when he is interacting with others in the community.

The above example outlines:

- Specific Learning Activities Affected by Disability:

'He is unable to learn and remember the tasks associated with going shopping by himself, or cooking, or being able to predict what is going to happen next and organise information in a logical way to make his decisions.'

- Type of Support Needed

'He requires a support person...'

- Level/frequency of Support Needed

'Kris is unable to be left alone within his home or the community as he needs supervision constantly...'

You do not have to write narrative style – bullet points are fine. As the Access Request Form is refined over time, you are likely to see more checkboxes introduced making the response process easier.

Doctors who prepare their own written report are less likely to receive requests for further information.

What specific item numbers can I claim against when providing evidence for a patient?

In providing evidence to support an Access Request, it is reasonable to expect that GPs will perform an examination of some description to assess or confirm the patient's current medical condition. If the time taken to assess and provide information to support an Access Request is part of this consultation, it may be claimed under a Medicare item.

Consistent with the operation of the Medicare Benefits Schedule, generally it is at a GP's discretion to select the Medicare item number that most appropriately reflects the nature of the consultation.

When a GP provides details about a patient without an associated consultation and without the patient present, a Medicare rebate is not payable.

A GP may use Medicare Items for a GP Management Plan and a Team Care Arrangement to identify and communicate with allied health and other professionals about the patient seeking access.

What are some tips for avoiding requests from the NDIS for further information?

When completing the 'Treating Professional' section of the Access Request Form (Part F of the current Access Request Form), keep the following in mind:

- Make sure you provide sufficient evidence to validate the diagnosis of a disabling condition, e.g. attach a letter of diagnosis.
- Make sure you provide sufficient evidence that the impairment is permanent. For the purposes of the NDIS, an impairment is permanent if it has not been, and is unlikely to be, substantially alleviated by conventional treatments. Therefore, it's important to adequately detail the patient's treatment history.
- Make sure you adequately describe the functional impact of the impairment. For each affected functional domain (mobility, learning, communication, self-care, social and self-management), consider what activity limitations the person experiences everyday as a result of their disability. You only need to provide this information for the domains that are significantly impacted (this may be one or more).
- Don't forget to provide evidence of how the impairment has affected the patient's ability to participate in school/study, work or the wider community (to clearly demonstrate its social or economic impact).

- Consider whether you are the most relevant treating professional to provide this information and if not, identify which professional/s you can reach out to for this information (or refer the patient on to for the extra support they need to complete the access request).

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