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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Notes for Assistive Technology Assessors of Prosthetics & Orthotics | | | | | | | | | | | | | | | |
| **There are specific templates available for the following types of AT:**   * General Assistive Technology Assessment * Continence Assessment * Prosthetics and Orthotics Assessment * Vehicle Modifications Assessment * Complex Home Modification Assessment * Dog Guide Assessment   The assessment information provided in this form will be used by the NDIA to understand how the specified AT will assist the participant to pursue their goals and to assess whether it is reasonable and necessary for the NDIS to fund AT support.  Using this template is not mandatory. If a provider elects to provide information in another format, they must include all information described in this template. Information provided needs to include an outline of the functional impact of each feature being recommended. This should include how the AT will support capacity building, promote independence and impact alternative forms of support.  The primary criteria NDIS delegates use when determining if a piece of equipment or modification is suitable for the NDIS to fund is section 34: reasonable and necessary supports of the [National Disability Insurance Scheme Act 2013 (NDIS Act; external) and section 34.](https://www.legislation.gov.au/Latest/C2018C00276)  Additional information on how the recommendation(s) will be considered in the context of specific supports can be found in the NDIS Operational Guidelines available online and the [NDIS (Supports for Participants) Rules 2013](https://www.legislation.gov.au/Details/F2013L01063).  **AT Strategy:** Supports will be provided in line with the NDIA’s AT Strategy that can be found at [Assistive Technology Strategy](https://www.ndis.gov.au/about-us/strategies/assistive-technology-strategy) and as outlined in [NDIS AT Complexity](https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications) document.  **Assistive Technology (AT) Assessor:** An AT assessor is able to assess a participant's needs and situation and identify the most appropriate AT, they may be an AT Mentor, allied health practitioner, continence nurse, rehabilitation engineer or other suitably qualified practitioner.  AT Assessors have obligations under the NDIS Provider Terms of Business, Quality and Safeguards Commission and their respective professional registration (where applicable) under Australian Health Practitioner Regulation Agency (AHPRA).  **Caution:** AT Assessors must be aware of and observe the law with regard to AT that is likely to restrain a participant. [National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018](https://www.legislation.gov.au/Details/F2018L00632)  The NDIA expects AT assessors to consider all options for addressing the participant’s disability related functional limitations and pursuing goals, including non-AT supports.  **NDIS AT Levels 3 & 4 trials:** Where the AT assessor and participant need to work with an AT supplier to trial and develop a specification for the AT support, reasonable supplier costs can be quoted, and if agreed, claimed against the participant’s plan (category ‘rental/trial’). Supplier specification/order details are required with this assessment to enable the NDIS to consider quotes/prices from the supplier.  Quotations should be attached where applicable (items < $1500 may be funded from the CORE consumables budget and do not require an assessment and quote). Quotations can include printouts of web orders and stock numbers from relevant State based equipment suppliers where relevant.  AT assessors can keep up to date at [NDIS provider assistive technology.](https://www.ndis.gov.au/providers/essentials-providers-working-ndia/providing-assistive-technologies-and-home-modifications) Participants can keep up to date at [NDIS participant assistive technology.](https://www.ndis.gov.au/participants/home-equipment-and-supports) | | | | | | | | | | | | | | | |
| Notes for navigating and editing this document | | | | | | | | | | | | | | | |
| **General Notes**  This document is protected so that only editable fields can be changed but additional rows in tables can be inserted as required.  All editable fields have unlimited text entry, and the document will expand in page length when large amounts of text are entered.  Spelling and grammar can be checked according to the word processor you are using.  The document can be navigated with just the Tab key to encompass varying modes of navigation and levels of computer skills  **JAWS Specific Comments**  Ins + F1 will read document information including the general layout, header and footer information  Ins + F6 will bring up a headings list allowing a JAWS user to jump to heading sections if desired  Ins + F7 will bring a list of web links embedded in the document.   * Ins + Z will turn on quick navigation fields so a JAWS user can use say “H” to jump to the next heading for easy navigation. | | | | | | | | | | | | | | | |
| PART 1 – Participant and Plan Management Details | | | | | | | | | | | | | | | | | |
| 1.1 NDIS Participant Details | | | | | | | | | | | | | | | |
| Name | | | | | |  | | | | | | | | | |
| Date of Birth | | | | | |  | | | | | | | | | |
| Age | | | | | |  | | | | | | | | | |
| NDIS Number | | | | | |  | | | | | | | | | |
| Address | | | | | |  | | | | | | | | | |
| Contact Telephone Number | | | | | |  | | | | | | | | | |
| Email | | | | | |  | | | | | | | | | |
| Preferred Contact Method | | | | | |  | | | | | | | | | |
| Nominee or Guardian Name | | | | | |  | | | | | | | | | |
| Nominee or Guardian Phone | | | | | |  | | | | | | | | | |
| NDIS Support Coordinator | | | | | |  | | | | | | | | | |
| Contact Details | | | | | |  | | | | | | | | | |
| 1.2 Plan Management Details | | | | | | | | | | | | | | | |
| Agency Managed | | | | | | | | | | |  | | | | |
| Self-Managed | | | | | | | | | | |  | | | | |
| Registered Plan Management Provider | | | | | | | | | | |  | | | | |
| Contact Details | | | | | | | | | | |  | | | | |
| PART 2 – Assessment | | | | | | | | | | | | | | | | | |
| 2.1 Background | | | | | | | | | | | | | | | |
| General: Describe participant’s current status which may include diagnosis, prognosis, co-existing conditions, disability, personal and instrumental activities of daily living, formal and informal support arrangements and life transitions. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| 2.2 Participant Goals | | | | | | | | | | | | | | | |
| If the participant’s NDIS plan has been made available, you can refer to the statement of participant’s goals and outline those relevant to the AT solution. | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| 2.3 Functional Assessment | | | | | | | | | | | | | | | | | |
| Summarise the assessment findings relevant to your recommendations (include aspects such as range of motion, strength, interpretation of valid outcome measure findings etc. as appropriate) and explain the impact on life roles. \*NDIS expects valid and reliable outcome measures are conducted, where possible, and records held by AT assessor for NDIS audit purposes. (e.g. AMPPRO, DASH) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| What are the applicant’s measurements? | | | | | | | | | | | | | | | | | |
| Height in cm | | | |  | | | | | | | | | | | | | |
| Weight in kg | | | |  | | | | | | | | | | | | | |
| 2.4 Current AT in use | | | | | | | | | | | | | | | | | |
| If it is the view of the NDIS participant or AT assessor that another relevant item of AT involved in goal achievement needs to be reassessed before this P&O assessment progresses, contact should be made with Participant’s LAC and/or Support Plan Coordinator at this point (e.g. where an Occupational Therapy upper limb assessment is required before a prosthetic recommendation can be made).  \*Document ‘Type of AT’ in detail; e.g. “jointed ankle foot orthosis with XX shells and XX joints”, or specific component name of prosthetic knees and feet.  **\*\*Note: To add rows for additional items navigate to any column. Either right mouse click or select the right context menu, move to and select Insert…move to and select Insert below to add a row. Repeat as required.** | | | | | | | | | | | | | | | | | |
| **Type of AT** | | | | **Usage** | | | | | **Participant’s report of suitability** | | | | | **Does it need reassessment? Yes or No. Details** | | | |
|  | | | |  | | | | |  | | | | |  | | | |
|  | | | |  | | | | |  | | | | |  | | | |
|  | | | |  | | | | |  | | | | |  | | | |
| **2.4.1** Outline any disability related functional limitation/s which need to be addressed to pursue the stated goal(s). Describe any limitations such as malfunctioning AT, no prior access to this AT etc. If no functional limitation changes, indicate why AT requires replacement in the plan period (e.g. ill-fitting). | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| PART 3 – Exploration of Options and Recommendation | | | | | | | | | | | | | | | | | |
| 3.1 Evaluation of other options | | | | | | | | | | | | | | | | | |
| Please provide information on alternatives considered to pursue goal/s including repairs, adjustments, therapy or AT training, and reasons why they were not considered suitable. Note that NDIA will generally fund the most cost-effective option, usually the minimum necessary componentry to pursue the goals, so lowest cost solutions must be considered. Where trials have been conducted or alternative AT used in the past, please give details of where the trials/use took place, for how long and the outcomes. Where necessary add further lines and/or attach further detail  **\*\*Note: To add rows for additional items navigate to any column. Either right mouse click or select the right context menu, move to and select Insert…move to and select Insert below to add a row. Repeat as required.** | | | | | | | | | | | | | | | | | |
| **Option** | | | **Describe the features or functions of AT solutions and other options trialled to address the goal** | | | | | | **Trialled (T) or considered (C)? Include trial details** | | | | **Describe why it was not considered suitable (not applicable for the preferred option)** | **Estimated cost (include training)** | | | |
|  | | |  | | | | | |  | | | |  |  | | | |
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|  | | |  | | | | | |  | | | |  |  | | | |
| 3.2 Recommended Solution (specification in Section 4) | | | | | | | | | | | | | | | | | |
| Describe the features or functions of solution that address the goal and functional need | | | | | | | | | | Include any trial details | | | | Estimated cost (include training | | | |
|  | | | | | | | | | |  | | | |  | | | |
|  | | | | | | | | | |  | | | |  | | | |
| 3.3 Evidence | | | | | | | | | | | | | | | | | |
| Explain the evidence for the recommended option as the most suitable and cost-effective, which will facilitate pursuit of the participant’s goal(s), facilitate participation, and/or improve life stage outcomes, compared to others considered (e.g. trial outcomes and consideration of long term benefit in both current and anticipated future needs, change/adjustment to personal care support need etc.). Particularly where a change in AT is recommended, briefly discuss why this is required e.g. rule out all mechanical knee options before considering only microprocessor knee unit options. | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| 3.4 Identify where change to other supports may be required (noting reduction or addition) for the recommended option including non AT supports and environmental modifications. | | | | | | | | | | | | | | | | | |
| Results of options review from perspective of participant and P&O assessor. | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| 3.5 Measuring success | | | | | | | | | | | | | | | | | |
| **3.5.1** What are the expected outcomes of providing this recommended support? E.g. specific goals achieved, other supports changed/reduced, etc.? | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **3.5.2** How will you measure whether these outcomes have been achieved? | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **3.5.3** When will you measure these outcomes? | | | | | | | | | | | | | | | | | |
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| PART 4 – Specification of Recommended P&O solution/device | | | | | | | | | | | | | | | | | |
| 4.1 Specification/Description of P&O AT solution/device | | | | | | | | | | | | | | | | | |
| Detail all necessary components required to meet participant’s goal. This must be detailed enough to ensure that reasonable and necessary can be accurately assessed in relation to the information supplied above (the fully completed Activity, Detail and quantity columns only of an AOPA compliant example quotation form can be attached to this form as an alternative) Reference: AOPA Quotation Development Guidance [Quotation Development Tool](https://www.aopa.org.au/sb_cache/events/id/488/f/AOPA-Quotation-Development-Tool-%20Final_2015.pdf) | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **4.1.1** (Capacity building) Professional assessment, specification, fitting and training | | | | | | | | | | | | | | | | | |
| **Activity** | | | | **Detail** | | | | | | | | **Quantity (hrs)** | | |
| *e.g. Clinical Assessment* | | | | *e.g. Clinical assessment; Goal setting* | | | | | | | | *eg 2 hrs* | | |
| *e.g. Device specification or measurement* | | | | *e.g. Casting/measuring for bilateral articulated AFO* | | | | | | | | *eg 3 hrs* | | |
| Clinical Assessment | | | |  | | | | | | | |  | | |
| Liaise with other health professionals | | | |  | | | | | | | |  | | |
| Device specification/measurement | | | |  | | | | | | | |  | | |
| Fitting and adjustment | | | |  | | | | | | | |  | | |
| Client education | | | |  | | | | | | | |  | | |
| Ongoing review/s (Identify intervals for first two years) | | | |  | | | | | | | |  | | |
| **Capital Building Hours Sub Total (hrs)** | | | | | | | | | | | |  | | |
| **Capital Building Hours x Hourly Rate Sub Total ($) (A)** | | | | | | | | | | | |  | | |
| **4.1.2** (Capital) Labour | | | | | | | | | | | | | | | | | |
| **Activity** | | | | **Detail** | | | | | | | | **Value ($)** | | |
| Fabrication/modification | | | |  | | | | | | | |  | | |
| Fitting/s | | | |  | | | | | | | |  | | |
| Administration | | | |  | | | | | | | |  | | |
| **Capital Labour Sub Total ($) (B)** | | | | | | | | | | | |  | | |
| **4.1.3** Componentry included in specification (Prosthetic) List details using ISO codes. | | | | | | | | | | | | | | | | | |
| **Component** | | | | **Detail** | | | | | | | | **Value ($)** | | |
| Connective componentry | | | |  | | | | | | | |  | | |
| Knee/Elbow | | | |  | | | | | | | |  | | |
| Foot/Wrist | | | |  | | | | | | | |  | | |
| Socket/suspension | | | |  | | | | | | | |  | | |
| Consumables | | | |  | | | | | | | |  | | |
| **Prosthetic Componentry Sub Total ($) (C)** | | | | | | | | | | | |  | | |
| **4.1.4** Componentry included in specification (Orthotic) List details using ISO codes. | | | | | | | | | | | | | | | | | |
| **Component** | | | | **Detail** | | | | | | | | **Value ($)** | | |
| Fabrication materials | | | |  | | | | | | | |  | | |
| Ankle Joints (Size; batch number) | | | |  | | | | | | | |  | | |
| Knee Joints | | | |  | | | | | | | |  | | |
| Other Joints | | | |  | | | | | | | |  | | |
| Prefabricated componentry | | | |  | | | | | | | |  | | |
| Custom made componentry | | | |  | | | | | | | |  | | |
| Consumables | | | |  | | | | | | | |  | | |
| **Orthotic Componentry Sub Total ($) (D)** | | | | | | | | | | | |  | | |
| **Quoted Capital Cost of Total Solution/Device ($) (A + B + C + D)** | | | | | | | | | | | |  | | |
| **4.1.5** Extra Features. List and Estimate cost of components/accessories (if any) that are desired by the participant but are unlikely to be assessed reasonable and necessary. Does the participant agree to pay for these from their own (not NDIS) funds? | | | | | | | | | | | | | | | | | |
| Yes | | |  | | | | | | | | | | | | |
| No | | |  | | | | | | | | | | | | |
| **Item(s)** | | | | **Detail** | | | | | | | | **Cost Estimate($)** | | |
|  | | | |  | | | | | | | |  | | |
|  | | | |  | | | | | | | |  | | |
|  | | | |  | | | | | | | |  | | |
| **4.1.6** The participant must be provided with maintenance and servicing information for their prosthetic/orthotic to remain in good working order. When will this be done? What are the warranty periods applying? | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Time from funding approval to expected orthosis/prosthesis provision (weeks): | | | | | | | | | | | |  | | | |
| **4.1.7** Is the participant at safety or other risk while waiting for the orthosis/prosthesis? Yes or no, give details | | | | | | | | | | | | | | | | | |
| Yes | | |  | | | | | | | | | | | | |
| No | | |  | | | | | | | | | | | | |
| Details | | |  | | | | | | | | | | | | |
| **4.1.8** Is a short term option necessary? E.g. immediate repair on current or prefabricated item to trial or rent to ensure safety prior to final orthosis/prosthesis provision. Yes or no, give details. | | | | | | | | | | | | | | | | | |
| Yes | | |  | | | | | | | | | | | | |
| No | | |  | | | | | | | | | | | | |
| Details | | |  | | | | | | | | | | | | |
| 4.2 Participant Agreement | | | | | | | | | | | | | | | |
| Do AT Assessor and Participant agree on the recommended option? | | | | | | | | | | | | | | | |
| Yes | | |  | | | | | | | | | | | | |
| No | | |  | | | | | | | | | | | | |
| Details | | |  | | | | | | | | | | | | |
| PART 5 – Details of Assistive Technology Assessor | | | | | | | | | | | | | | | |
| **DECLARATION** (indicate all relevant sections that apply) | | | | | | | | | | | | | | | |
| I certify that I meet the NDIA expectations of AT assessor provider suitability (including understanding of the current NDIS Act, Rules and Operational Guidelines) to assess the type of assistive technology and associated supports, at the level of complexity required by this participant. | | | | | | | | | | | | | |  | |
| I will provide appropriate evidence to the NDIA and/or Quality and Safe Guards Commission if and as requested. | | | | | | | | | | | | | |  | |
| I understand and acknowledge that the NDIA and participant will rely on my professional advice to select, source and implement this assistive technology. | | | | | | | | | | | | | |  | |
| This assistive technology has been assessed by the treating multi-disciplinary team and I have completed the AT assessment on behalf of that team. | | | | | | | | | | | | | |  | |
| **Assessor’s Details** | | | | | | | | | | | | | | | |
| Name | | | | | | |  | | | | | | | | |
| NDIS Provider Registration number (where applicable) | | | | | | |  | | | | | | | | |
| Phone | | | | | | |  | | | | | | | | |
| Email | | | | | | |  | | | | | | | | |
| Signature | | | | | | |  | | | | | | | | |
| Qualification | | | | | | |  | | | | | | | | |
| Date of Assessment | | | | | | |  | | | | | | | | |
| Date of Report | | | | | | |  | | | | | | | | |
| PART 6 – Consent to Collect and Share Your Information – Provider AT Assessment and Quotation(s) | | | | | | | | | | | | | | | |
| **For the participant to complete**  As a participant who requires assistive technology supports, the National Disability Insurance Agency (NDIA) may need to contact your AT assessor and / or AT supplier to discuss information within your assistive technology assessment and quotation(s). This will assist the NDIA with determining whether your request for assistive technology support(s) can be provided to you under the NDIS. Do you consent to the NDIA collecting and disclosing your information including from these third parties mentioned above, in relation to your assistive technology assessment and quotation? | | | | | | | | | | | | | | | |
| Yes, I consent | | | | | | | | | |  | | | | | |
| No, I do not consent | | | | | | | | | |  | | | | | |
| Participant’s Signature | | | | | | | | | |  | | | | | |
| I understand that I am giving consent to the NDIA to do the things with my information set out in this section. I understand that I can withdraw my consent for the NDIS to do things with my information at any time by letting the NDIA know. | | | | | | | | | | | | | |  | |
| I understand that I can access the NDIA’s Privacy Notice and Privacy Policy on the [NDIA website](https://www.ndis.gov.au/providers/providing-at.html) or by contacting the NDIA. | | | | | | | | | | | | | |  | |
| Signature | | | | | | | | | |  | | | | | |
| Date | | | | | | | | | |  | | | | | |
| Full name | | | | | | | | | |  | | | | | |
| **If you have signed this Form on behalf of the NDIS participant**, please complete the details below. It is an offence to provide false or misleading information.  We may require you to provide evidence of your authority to sign on behalf of the person. | | | | | | | | | | | | | | | |
| Signature | | | | | | | | | |  | | | | | |
| Date | | | | | | | | | |  | | | | | |
| Full Name of person completing this form (please print): | | | | | | | | | |  | | | | | |
| Relationship to participant or person wishing to become an NDIS participant: | | | | | | | | | |  | | | | | |