

Service List

SECTION 1: BUSINESS DETAILS

ENTITY TYPE: (Individual Sole Trader/Australian Private Company)

TITLE OF APPLICANT: (Tick box that applies)

- ☐MR
- ☐MRS
- ☐MISS
- ☐MS
- ☐DR

FULL NAME:

LEGAL TITLE OF DIRECTOR/S:

- ☐MR
- ☐MRS
- ☐MISS
- ☐MS
- ☐DR

FULL NAMES:(IF MULTIPLE DIRECTORS PLEASE LIST FULL NAMES, LEGAL TITLE AND DATE OF BIRTH)

DATE OF BIRTH:

____/____/____

BUSINESS ADDRESS:

EMAIL/S:

CONTACT NUMBER/S:

ABN (AUSTRALIAN BUSINESS NUMBER):

REGISTERED ABN NAME:

TRADING NAME:

REGISTERED BUSINESS ADDRESS:

CHOOSE WHICH STATE YOU WISH TO OPERATE IN: (TICK BOXES THAT APPLY)

- ☐ VIC
- ☐ ACT
- ☐ NSW
- ☐ QLD
- ☐ TAS
- ☐ SA
- ☐ NT
- ☐ WA

IS YOUR POSTAL ADDRESS A P.O BOX?

YES / NO

GST REGISTERED?

YES / NO

TYPE OF BUSINESS: (TICK BOX THAT APPLIES)

- ☐ PARENT ORGANISATION
- ☐ INDIVIDUAL WITH ABN
- ☐ ENTITY WITH AN ABN

LEGAL ENTITY TYPE: (TICK BOX THAT APPLIES)

- ☐ AUSTRALIAN PRIVATE COMPANY
☐ INDIVIDUAL/ SOLE PROPRIETOR
☐ PARTNERSHIP
☐ AUSTRALIAN PUBLIC COMPANY
☐ INCORPORATED ASSOCIATION, ORGANISATION
☐ TRUSTEE ON BEHALF OF TRUST, LOCAL GOVERNMENT
☐ STATE & TERRITORY GOVERNMENT
☐ ABORIGINAL CORPORATION

SECTION 2: SELECT YOUR SERVICES

*Please Note: Some services may require a qualification or previous work experience.
 (Any service with an * will require a qualification) (Please refer to the emailed 'HPA Service Guide' for more information)*

Registration Group Number		Registration Group Name
		General Registration Groups <i>***Relevant work experience is recommended but NOT always essential***</i>
0101	<input type="checkbox"/>	Accommodation / Tenancy Assistance
0102	<input type="checkbox"/>	Assistance to Access and Maintain Employment or Higher Education
0104	<input type="checkbox"/>	High-Intensity Daily Personal Activities - Please select which high-intensity services you are able to provide <input type="checkbox"/> Complex Bowel Care <input type="checkbox"/> Enteral (Naso-Gastric Tube - Jejunum or Duodenum) Feeding and Management <input type="checkbox"/> Tracheostomy Management <input type="checkbox"/> Urinary Catheter Management <input type="checkbox"/> Ventilation Management <input type="checkbox"/> Subcutaneous Injections <input type="checkbox"/> Pressure Care and Wound Management <input type="checkbox"/> Severe dysphagia management
0106	<input type="checkbox"/>	Assistance in Coordinating or Managing Life Stages, Transitions and Supports
0107	<input type="checkbox"/>	Daily Personal Activities
0108	<input type="checkbox"/>	Assistance with Travel/Transport Arrangements
0115	<input type="checkbox"/>	Assistance with Daily Life Tasks in a Group or Shared Living Arrangement (SIL)
0116	<input type="checkbox"/>	Innovative Community Participation
0117	<input type="checkbox"/>	Development of Daily Living and Life Skills
0120	<input type="checkbox"/>	Household Tasks
0125	<input type="checkbox"/>	Participation in Community, Social & Civic Activities
0127	<input type="checkbox"/>	Management of Funding for Supports in Participants' Plans
0129	<input type="checkbox"/>	Specialised Driver Training

0130	<input type="checkbox"/>	Assistance Animals
0131	<input type="checkbox"/>	Specialised Disability Accommodation
0133	<input type="checkbox"/>	Specialised Supported Employment
0136	<input type="checkbox"/>	Group and Centre Based Activities
<u>Professional Registration Groups</u> ***Qualification's Required***		
0110	<input type="checkbox"/>	Specialist Positive Behaviour Support*
0114	<input type="checkbox"/>	Community Nursing Care*
0118	<input type="checkbox"/>	Early Intervention Supports for Early Childhood*
0119	<input type="checkbox"/>	Specialised Hearing Services*
0121	<input type="checkbox"/>	Interpreting and Translation*
0126	<input type="checkbox"/>	Exercise Physiology and Personal Training*
0128	<input type="checkbox"/>	Therapeutic Supports*
0132	<input type="checkbox"/>	Specialised Support Coordination*
0134	<input type="checkbox"/>	Hearing Services*
0135	<input type="checkbox"/>	Customised Prosthetics*
<u>Home and Vehicle Modification Registration Groups</u>		
0109	<input type="checkbox"/>	Vehicle Modifications*
0111	<input type="checkbox"/>	Home Modifications*
<u>Assistive Technology and Equipment Registration Groups</u>		
0103	<input type="checkbox"/>	Assistive Products for Personal Care and Safety
0105	<input type="checkbox"/>	Personal Mobility Equipment
0112	<input type="checkbox"/>	Assistive Equipment for Recreation
0113	<input type="checkbox"/>	Vision Equipment
0122	<input type="checkbox"/>	Hearing Equipment
0123	<input type="checkbox"/>	Assistive Products for Household Tasks
0124	<input type="checkbox"/>	Communication and Information Equipment

Please circle **YES** or **NO** for the following questions:

ADMINISTERING MEDICATIONS?

YES / NO

DISPOSAL OF WASTE, INFECTIOUS & HAZARDOUS SUBSTANCES?

YES / NO

ARE YOU IMPLEMENTING RESTRICTIVE PRACTICES?

YES / NO

ARE YOU A RESIDENTIAL AGED CARE PROVIDER?

YES / NO

SECTION 3: SUSTAINABILITY

The NDIS Commission will assess the suitability of the Applicant, including the Applicant's Key Personnel, in conjunction with the qualifications, competencies and experience of the Applicant. The below questions will be used as part of the suitability assessment. The answers to these questions will be assessed on a case-by-case basis.

This information must be included for all Key Personnel in your organisation, including Directors, Board Members, Chief Officers, and any other Senior Management.

Question 1: Has the Applicant ever been in receivership, subject to a winding-up order and/or under administration?

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This includes where the Applicant:

- Is under external administration (or equivalent in-home jurisdiction)
- Is subject to a winding-up order or an application for winding up (or equivalent in home jurisdiction)
- Has a receiver or receiver and manager been appointed to the company (or equivalent in-home jurisdiction)
- Has a company administrator been appointed to the company (or equivalent in-home jurisdiction)?
- Is the company currently subject to a deed of company administration (or equivalent in-home jurisdiction)?
- Has received notice that action for the involuntary cancellation of its incorporation had commenced or is proposed?

YES / NO

Question 2: Have any of the Applicant's Key Personnel ever been convicted of an indictable offence?

This includes convictions of indictable offences against a law of the Commonwealth, State or Territory or other jurisdiction (including foreign country). Where the answer is yes, please indicate which Key Personnel was convicted, and the nature of the conviction.

YES / NO

Question 3: Is the Applicant, or any of the Applicant's Key Personnel an insolvent under administration, or been an insolvent under administration (or equivalent in-home jurisdiction)?

YES / NO

Question 4: Has the Applicant, or any of the Applicant's Key Personnel commenced bankruptcy proceedings?

YES / NO

Question 5: Have any of the Key Personnel been disqualified as a director of a company, and/ or disqualified from managing corporations?

YES / NO

Question 6: Have any of the Applicant's Key Personnel, or the Applicant overall, been subject to any findings or judgement in relation to fraud, misrepresentation or dishonesty?

This includes where the Applicant's Key Personnel or the Applicant overall has: Been the subject of any findings or judgment in relation to fraud, misrepresentation or dishonesty in any administrative, civil or criminal proceedings, or is currently party to any proceedings that may result in the applicant being the subject of such findings or judgment been disqualified from managing corporations under Part 2D.6 of the Corporations Act 2001.

YES / NO

Question 7: Has the Applicant or any of the Applicant's Key Personnel been subject of any investigation, adverse finding or enforcement by any regulator, including authorities responsible for the quality or regulation of services for people with disability?

This includes any adverse findings or enforcement action by:

- A department of or authority or the other body established for a public purpose by the Commonwealth, a State or Territory, including those with responsibilities relating to the quality or regulation of services provided to the people with a disability, older people or children.
- The National Disability Insurance Agency.
- The Australian Securities and Investment Commission.
- The Australian Charities and Not for profits Commission.
- The Australian Competition and Consumer Commission.

- The Australian Prudential Regulation and Authority.
- The Australian Crime Commission.
- AUSTRAC:
 - A work health and safety authority of a State or Territory.
 - A body of a State or Territory that has similar responsibilities to those

mentioned above enforcement action may include:

- Banning Orders.
- Cancellation of NDIS Registration.
- Involuntary cancellation of an entity's incorporation status.
- Any other compliance or enforcement activity.

YES / NO

Question 8: If you have circled YES to any of the above questions, please provide a detailed comment below with an explanation.

SECTION 4: DECLARATION

<p><u>PRODA</u></p> <p>Have you previously established a PRODA (Provider Digital Access) Account?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>**ONLY DO THIS STEP IF YOU REQUIRE REGISTRATION FOR THE NDIS**</p>	<p>IF NO - Skip this step.</p> <p>IF YES - Please provide us with your PRODA details below. We will call you upon logging in to retrieve the verification codes from you. (You will not have to send us ID)</p> <p>Username: _____</p> <p>Password: _____</p>
<p><u>Workers Screening ID - (ONLY IF YOU HAVE ONE)</u></p> <p>All NDIS Providers <i>must</i> complete a Workers Screening Check. (This isn't required until prior to your audit in roughly 4 weeks)</p>	<p>Workers Screening ID Number: _____</p> <p>Date of Completion: _____/_____/_____</p>
<p><u>ID Verification</u></p> <p>Please attached 3 of the required IDs for your registration. Each form of ID must be clear and legible.</p> <p><i>*ONLY DO THIS STEP IF YOU REQUIRE REGISTRATION FOR THE NDIS*</i></p> <p>Recommended Forms of ID - (We require all 3)</p> <ul style="list-style-type: none"> • Medicare Card* • Australian DriversLicence* • Australian Passport* <p>Alternative - (Any 2 of these required)</p> <ul style="list-style-type: none"> • Medicare Card. • Australian DriversLicence. • Australian Passport. • ImmiCard <p>(+1 of the following)</p> <ul style="list-style-type: none"> • Australian Passport. • Australian Birth Certificate. • Australian Citizenship (Front and Back). • Foreign Passport Certificate of Citizenship by Descent. • ImmiCard. 	

Health Provider Assist Pty. Ltd. accepts no responsibility for the accuracy or completeness of any information provided.

I _____, confirm that the information provided on and in connection with this form is true, complete, and accurate. I allow Health Provider Assist Pty. Ltd. to create or make changes to my PRODA in relation to our contract and this form if required. I allow Health Provider Assist Pty. Ltd. to use this information in completing the required services as agreed upon in the service agreement and put this information forward to potential clients and to the online HPA Portal.

Signature:

Date: ____/____/____

HPA