NDIS Service Agreement

All queries please call 03 8506 4644

Please complete and either:

Email ALL pages to ndis@conticare.com.au

Mail to PO BOX 8002 East Brighton VIC 3187

Fax to 03 9569 9850

The compulsory fields must be completed, or they cannot be processed.

Provider Name:	Conticare – (NDIS no. 405 003 4373)
Participant Name:	
NDIS Number:	
Who is arranging payment of your invoices?	Conticare Planner / Participants
Date of birth:	
Contact Person:	
Contact Number:	
Email Address:	
Delivery Address:	
Delivery Instructions:	Authorized to leave [ ] Signature required [ ] Other [ ]
Planner Name :	
Planner Contact Number :	
Planner Email :	
Plan Dates :	From: To:

The Provider agrees to :

Provide the required support to satisfy the Participant's needs at the Participant's preferred time.

Communicate openly and honestly in a timely manner.

Treat the Participant with courtesy and respect.

Listen to the Participant's feedback and resolve problems quickly.

Protect the Participant's privacy and confidential information.

Responsibilities of Participant / Participant's representative

a) Inform the Provider about how they wish the supports to be delivered to meet the Participants needs.

b) Give the Provider the required notice if the Participant needs to end the Service Agreement.

c) Let the Provider know immediately if the Participant's NDIS plan is suspended or replaced by a new NDIS plan or the Participant ceases to be a Participant in the NDIS.

d) To provide adequate information to the Provider so a service booking can be made and funds claimed whilst remaining under budget.

Payments

The Participant has nominated the NDIS to manage the funding for supports provided under this Service Agreement. After providing those supports, Conticare will claim payment for those supports from the NDIS. If Conticare is unable to claim the order amount from the NDIS, the Participant will be liable for the balance on the account.

Agreement signatures

Signature of Participant /Participant's representative

_____

Name of Participant / Participant's representative

_____

Date

Signature of authorised person from Provider

_____

Name of authorised person from Provider