SUPPORT PLANNING AND SERVICE AGREEMENT COLLABORATION POLICY AND PROCEDURES

Full Care Lifetime's aim is to work with participants, families, advocates, communities and other providers to achieve the best outcome for the participant. This communication will allow all parties to share ideas and knowledge to ensure that the supports are relevant, appropriate and in line with the service agreement.

Full Care Lifetime is committed to ensuring that the staff understand the beneficial aspects of a collaborative approach to the participant.

POLICY

This collaborative approach requires staff to work with relevant parties when:

- Locating key worker with a family and other provider.
- Working with other providers in the supply of supports or services.
- Assisting the participant in transitioning and exiting the service.
- Building the participant's capacity.
- Planning with supports for the participant.
- Developing Service Agreements.
- Documenting the annual review report of the support plan for any relevant changes.

Staff must cooperate with other agencies in the delivery of service. This collaboration may include initial contact, sharing ideas and input from participants, families and advocates following through on ideas of provider, and actively listening to discussions. We will collaborate with all relevant parties to provide participants with the opportunity to access a service network that meets the full range of their needs. Director will contact and establish communication with the relevant service provider so our organisation can maintain collaborative relationships and protocols and participate in networks with relevant agencies.

Information, knowledge and skills are communicated and shared between the participant, family, advocate, the provider, and other collaborating providers with the participant's consent. Full Care Lifetime will work with the participant and their family and advocate ensuring that the participant maintains the functionality.

PROCEDURE

Key Worker

Participants and families may require assistance to locate the right person for the participant, so our team will undertake the following process:

- Discuss the participant's requirements with participant, family and advocate.
- Gain formal written consent to share and gather information with other providers.
- Contact other service providers working with the participant to collaborate and determine the criterion.
- Identify at least one (1) key support worker and contact participant, family and advocate, and the other providers.

- Identify the risks for the participant and the reliability of participant's daily activities on the nature of the support.
- Update the health and safety risks of the participant in case of support disruption in the risk assessment form.
- Annually review any known change of circumstances in participant situation, update will be done on the Client Priority Matrix for updating the support plan accordingly.
- Inform the participant, family and advocate of the identified person to allow them to select.
- Record the process undertaken and the results in the participant's service agreement.

Collaborating with Other Providers

Director or their delegate will make initial contact with other providers, after gaining consent from the participant, family and advocate. Various methods will be used to maintain contacts such as email, phone and networking. All records of contact are kept in the participant's service agreement.

Transition and Exit

The participant's needs, interests or aspirations may change during the delivery of their supports. These changes may lead to a need to transition to or exit from their current service. If this occurs, then we will, with the consent of a participant, contact the relevant service provider to:

- Collaborate with providers and participants to develop a plan of action.
- Send or request documents relevant to the participant.
- Communicate current supports, practices and needs to enable the participant to transfer or exit smoothly
- Identify risks and develop a Risk Management Plan.
- Develop a process for each participant - communicate the details to the participant, work with the participant during the process and review after the transition.
- Document the process in the Participant's Support Plan.

Risks associated with each transition to or from Full Care Lifetime are identified, documented and responded to. (See Transition and Exit Policy and Risk Management Policy)

Capacity building

The participant's capacity building process is designed to improve and retain their skills and knowledge, so they can maintain and improve their functionality.

To build and support the participant's functional capacity Full Care Lifetime will collaborate with:

- The participant, their family and advocate to affirm, challenge, and support.
- Other providers to further develop participant's skills and to improve practice and relationships.

Participant Outcomes

Collaboration with participant, family and advocate is the basis ensuring functional outcomes are based on the participant's needs, priorities, and their skills. The collaboration is to be recorded in the service agreement.

Support Planning

During the assessment and support planning process, collaboration is undertaken with participant, family and/or advocate:

- Complete a risk assessment.
- Document a risk assessment.
- Plan appropriate strategies to treat known risks.
- Implement appropriate strategies to treat known risks.
- Review annually or earlier according to their changing needs or circumstances.

Service Agreements

Full Care Lifetime will collaborate with the participant to develop a service agreement which establishes:

- Expectations
- Explains the supports to be delivered, and
- Specifies any conditions attached to the delivery of supports, including why these conditions are attached.

With the consent or direction from the participant Full Care Lifetime collaborates in the development of the support plan, with other providers to:

- Develop links
- Maintain links
- Share information
- Meet participant's needs

Specialist Support Coordination Policy

The purpose of this policy is to ensure that Specialist Support Coordination (SSC) is delivered in a manner consistent with NDIS Practice Standards, specifically under Module 4 – Specialist Support Coordination, and aligned with the goals of promoting participant choice, capacity building, safety, and risk management. This policy outlines the roles, responsibilities, and ethical obligations of staff delivering SSC at Fullcare Lifetime.

Policy

Scope

This policy applies to:

- All Fullcare Lifetime staff delivering Specialist Support Coordination.
- Participants funded for Specialist Support Coordination under their NDIS plan.
- Line managers and clinical supervisors responsible for overseeing SSC work.

Definition of Specialist Support Coordination: Specialist Support Coordination is a time-limited, capacity-building support funded by the NDIA for participants with complex needs, including those experiencing significant risk factors or barriers to implementing their NDIS plans. It requires a qualified allied health professional and involves the development of individualised intervention strategies, intensive coordination, and risk mitigation planning.

Key Responsibilities of Specialist Support Coordinators

- Fullcare Lifetime's Specialist Support Coordinators are responsible for:
- Developing and implementing intervention strategies to reduce risk and complexity.
- Coordinating multiple services, including informal, mainstream, and funded supports.
- Designing tailored crisis prevention plans in collaboration with the participant and their network.
- Monitoring outcomes and adjusting plans as participant needs evolve.
- Supporting transitions, including housing, justice, education, or health pathways.
- Ensuring informed choice, clear communication, and accessible information sharing.
- Maintaining high-quality documentation, including service agreements, progress notes, risk assessments, and NDIA reports.

PROCEDURE

Staff Qualifications

All SSC staff at Fullcare Lifetime must meet the following criteria:

- Hold an Allied Health qualification in Social Work, Psychology, Occupational Therapy, or other relevant fields.
- Be registered or eligible for registration with their professional board (e.g. AHPRA or AASW).
- Have a minimum of 2 years' experience in complex disability service provision or related practice.
- Undertake regular training and supervision to maintain quality and ethical standards.

Conflict of Interest and Choice & Control

Fullcare Lifetime recognises that Specialist Support Coordinators may also work in organisations that provide other NDIS supports. To manage conflicts of interest:

- Participants must receive transparent and factual information about all support options, including competitors.
- Participants must be informed if Fullcare Lifetime provides other services and must be reassured that their choice will not influence the delivery of SSC.
- Referrals to and from providers must be objectively documented and stored in participant records.
- SSC staff must not recommend services in which they or Fullcare Lifetime hold a commercial interest unless the participant has been fully informed and alternate providers were also presented.

NDIA and Practice Standard Compliance

In accordance with NDIS Quality Indicators – Module 4, SSC at Fullcare Lifetime ensures:

- Proactive identification and understanding of participant risk factors.
- Inclusive planning involving the participant, their network, and other service providers.
- Coordination of services that reduce complexity and promote stability.

- Continuous evaluation and reporting to the NDIA.
- Provision of all services in a participant-centred, trauma-informed, and culturally sensitive manner.

Documentation & Reporting

SSC staff are responsible for:

- Keeping comprehensive progress notes that detail support actions, risk mitigations, and participant decisions.
- Completing and submitting all NDIA required reports within set timeframes.
- Logging all hours in accordance with participant funding and plan allocations.
- Ensuring service bookings and agreements are updated and reflect active work.

Case Escalation & Supervision

If a participant's risk level escalates (e.g., homelessness, family breakdown, safety risk):

- The SSC must notify their supervisor immediately.
- A case conference must be convened with relevant stakeholders.
- A revised intervention strategy must be documented and shared appropriately.

Supervision of SSC staff will occur at least monthly, and complex cases will receive additional oversight.

Participant Rights and Advocacy

Fullcare Lifetime ensures that:

- SSC staff do not act as participant advocates in NDIA review processes.
- Independent advocates are referred if participants need support to challenge NDIA decisions.
- Participants are supported to exercise control, ask questions, and understand the purpose of all activities undertaken within their plan.

Review and Continuous Improvement

This policy will be reviewed annually or in response to:

- Changes to NDIS Commission standards
- Outcomes of internal audits
- Staff or participant feedback

Feedback and incidents related to SSC will be used to improve practices and inform training.