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**Overview of the Service Agreement**

**National Disability Insurance Scheme**

Welcome. You have chosen XXXXX Speech Pathologist to provide your Speech Pathology services under the National Disability Insurance Scheme.

This written agreement will help to ensure that you and XXXXX Speech Pathologist have an agreed set of expectations of how your service will be delivered.

The agreement will also outline what each party’s responsibilities and obligations are and how to resolve any problems, should they arise.

When developing your agreement, it would be helpful if you could provide a copy of your National Disability Insurance Scheme (NDIS) plan to help guide us.

PLACE YOUR LOGO HERE

PLACE YOUR ADDRESS HERE

Things we will specify in your agreement include:

* The supports that will be provided;
* How you would like your services to be delivered;
* The duration of the supports that will be provided;
* When and how your agreement will be reviewed;
* How you and XXXXX, Speech Pathologist, will deal with any issues, should they arise;
* What your responsibilities are in the agreement – for example: to work with you to provide services that meet your needs;
* What notice by either party is required to end the agreement.

**Service Agreement – Participant # XXXXXXX**

This agreement has been made between:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant)

and

XXXXX Speech Pathologist (Provider).

This Agreement will commence on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and will conclude on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

XXXXX, Speech Pathologist, agrees to provide the following reasonable and necessary supports for a period of:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Support Item** | **Hourly Rate** | **Hours** | **Frequency** | **Total Cost** |
| **15\_048\_0128\_1\_3 – Speech Therapy**  | $175.57 |  |  |  |
| **15\_048\_0128\_1\_3 – Travel** | $175.57 |  |  |  |
| **15\_048\_0128\_1\_3 – NDIS Goal Review (as required by NDIA)** | $175.57 |  |  |  |
| **TOTAL** |  |  |  | **$** |

□ Three (3) months then review

□ Twelve (12) months then review

A two (2) hour review of goals with both the parent and child will be required one (1) month prior to the end of your NDIS plan and a report written for your next NDIS plan. This will be charged at the scheduled NDIS rate of $175.57 p/hr.

## Payment for Services

The fee for supports are outlined in your NDIS plan and will be billed directly by XXXXX, Speech Pathologist. Payment will be provided by:

* Claim directly from NDIS portal. Send an invoice showing the claimed amount to :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* An organisation manages my funds for me. Send an invoice to :
	+ Organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* I will pay the fee myself (or I self manage my NDIA plan). Send me an invoice to :

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NB. XXXXXX will not provide services on public holidays or during school holidays unless pre-arranged.

**Provider’s responsibilities:**

XXXXX, Speech Pathologist, agrees to:

Work with you in the provision of reasonable and necessary support(s) including:

* Review the service with you each three (3) or twelve (12) months as indicated earlier in this document, or sooner if the need is identified;
* Work with you to provide support that fits your needs and your preferred times;
* Treat you with courtesy and respect;
* Consult with you on decisions about how your supports are provided;
* Listen to your feedback and resolve problems quickly;
* Keep clear records on services provided to you.

**Participant’s responsibilities:**

I, (Participant or parent/guardian)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to :

* Work with XXXXX Speech Pathologist to ensure that the services and supports delivered meet my needs;
* Treat all XXXXX Speech Pathology staff with courtesy and respect;
* Talk to XXXXX Speech Pathologist if I have any concerns about the services or supports being provided.

**Changes to Service Delivery:**

If you, as a person we support, fail to attend two (2) of your scheduled appointments with no notice we will claim the total of your missed sessions through the agreed claiming method as stated earlier in this document. Following this, a $50 Fail to Attend Fee will be invoiced to you and cannot be claimed through NDIS.

XXXXX, Speech Pathologist, requires a minimum of two (2) weeks notice if you are going to be on holiday or no longer require a scheduled appointment.

Should it be identified as unsafe to continue service without the additional support included in your NDIS plan, XXXXX, Speech Pathologist, reserves the right to suspend service until those additional supports are in place.

If you have cancelled or FTA (fail to attend) on three (3) consecutive appointments, XXXXX Speech Pathologist, reserves the right to deem this agreement as being cancelled.

**Ending This Agreement:**

Should either party require this agreement to end, we agree to give one (1) month’s notice. If either party breaches this agreement, the requirement of notice will be waived.

**Agreement Signatures:**

All parties understand and agree to the terms and conditions outlined in this service agreement.

**Signature of Participant**

Participant Name : Date:

Participant Signature :

Witness Signature :

Witness Full Name :

**Signature of Guardian (on behalf of participant (if applicable))**

Guardian Name : Date:

Guardian Signature:

Witness Signature :

Witness Full Name:

**Signature of Authorised Provider Representative**

Provider’s Name:

Date:

XXXXX (Speech Pathologist):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:

Witness Full Name: