NDIS SERVICE AGREEMENT

ABN:39108974554
Provider:4050034373
Tel : 03 8506-4644

Send your form to :

E-mail: ndis@conticare.com.au
Mail: PO Box 8002 East Brighton VIC 3187
Fax: 03 9569 9850

*Compulsory Fields Must Be Completed

***Participant Name:**	
***NDIS Number:**	
***Date Of Birth:**	
***Who Is Arranging Payment Of Your Invoices?**	[ ] Self Managed [ ] Planner Managed [ ] NDIA Managed
***Contact Number:**	
Delivery Address:	
Planner Name :	
Planner Contact Number :	
Planner Contact Number :	
Planner E-mail :	
Planner ID Number :	
Plan Dates :	From: ___________To: ___________
***Consent For NDIA To Exchange Information?**	[ ] YES [ ] NO

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 confdential information.

Responsibilities of Participant / Participant’s representative

a) Inform the Provider about how they wish the supports to be delivered to meet the Participant's 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.

e) To give consent for the NDIA to exchange information with the Provider

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

Participant or Participant’s Representative	**Provider's Representative**
Name	Name
Signature	Signature
Date	Date