



Flexible Support Packages Guidelines

*(Incorporating Making a Difference, Early Choices,
Continuity of Care & Family Choice)* - September 2003
Disability Services

Table of Contents

1. Introduction.....	1
1.1 Background.....	1
1.2 Alignment of Flexible Support Packages Programs.....	2
1.3 Flexible Support Package Guidelines.....	2
2. Goals and Objectives	3
2.1 Goals	3
2.2 Objectives.....	3
3. Target Group and Prioritisation	4
3.1 Target Group.....	4
3.2 Priority of Access.....	4
4. Service Description.....	6
4.1 Flexible Support Packages	6
4.2 Package Types	7
4.3 Key Elements of Flexible Support Packages.....	7
4.4 Receiving Referrals	7
4.5 Access	8
4.6 Allocation	8
4.7 Assessment.....	8
4.8 Development of a Support Plan	9
4.9 Expenditure Plan	9
4.10 Implementation of the Support Plan.....	10
4.11 Monitoring.....	10
4.12 Review of Plan.....	10
4.13 Closure	10
5. Quality	12
5.1 Standards.....	12
5.2 Monitoring against Standards	12
6. Practice Guidelines	13
6.1 Transition and Relocation	13
6.1.1 Transition and Relocation Process.....	13
6.1.2 Alternatives to Transition.....	13
6.2 Promoting Partnerships	14
6.3 Multi-Source Support	14
6.4 Best Practice Principles (for Children with Disabilities & Complex Care Needs).....	14
6.5 Permanency Planning Principles.....	15
6.6 Shared Care Arrangements	15
6.7 Grievances	15
6.8 Privacy.....	15
6.9 Statewide Services	16
6.10 Insurance	16
Appendix 1.....	17
Description of Individual Programs.....	17
Appendix 2.....	19
Family Centred Practice	19

Appendix 3	20
Funding and Targets	20
Appendix 4	21
Discretionary Funding	21
Appendix 5	25
Best Practice Principles (Children aged 0-18 with Disabilities & Complex Support Needs) ...	25
Appendix 6	26
Permanency Planning Principles	26
Appendix 7	27
Shared Care Arrangements.....	27
Appendix 8	28
Privacy.....	28
Appendix 9	31
Glossary of Terms.....	31

Policy & Funding Plan

http://hnb.dhs.vic.gov.au/ds/disabilitysite.nsf/pages/prov_fund0001

Standards

http://hnb.dhs.vic.gov.au/ds/disabilitysite.nsf/pages/prov_quality_standards

Capital Development Guidelines

<http://www.dhs.vic.gov.au/pdfs/capdev/polproc.pdf>

Privacy

<http://www.dhs.vic.gov.au/privacy>

1. Introduction

1.1 Background

Flexible Support Packages including *Early Choices*, *Making a Difference (MaD)*, *Continuity of Care* and *Family Choice* provide case management and/or discretionary funding for children and adults with a disability, their families and carers.

Flexible Support Packages are provided by non-government organisations (service providers) in partnership with individuals, their families and carers to develop strategies that facilitate access to primary care and community services and build informal support networks in the community. Flexible Support Packages can provide discretionary funding to complement the existing service system and ensure flexible and responsive support options to enable individuals to remain living in the community.

Prior to July 2002, the Community Care Division of the Department of Human Services (DHS) had responsibility for *Early Choices* and the *Family Choice* programs. The *Making a Difference* and *Continuity of Care* programs were the responsibility of Disability Services. In July 2002 all programs aligned and came under the auspice of the Disability Services Division. Metropolitan Health and Aged Care continue to provide the greater proportion of funds to the *Family Choice* Program.

1.2 Alignment of Flexible Support Packages Programs

The State Disability Plan¹ identifies one of its major goals as:

'To enable people with a disability to pursue their own individual lifestyles, by encouraging others to respect, promote and safeguard their rights and by strengthening the disability support system so that people's individual needs can be met.'

A priority strategy to achieve this goal is to reorient disability supports to better respond to people's needs at different ages and stages in their lives. The alignment of Flexible Support Package programs reduces the fragmentation of services and provides the capacity to implement whole of life planning that promotes a continuum of care for children and adults, their families and carers. Furthermore, the alignment begins to streamline administrative processes for service providers such as data collection and performance monitoring requirements.

For a description of the individual programs included in the alignment refer to **Appendix 1**.

1.3 Flexible Support Package Guidelines

The Flexible Support Package guidelines have been revised with the intention of integrating key aspects of the *Early Choices, Family Choice, Continuity of Care* and *Making a Difference* Programs. The Flexible Support Package Guidelines outline the philosophy and objectives of Flexible Support Packages, provide a framework for the operation of the packages and describe linkages with other programs in the broader service system. The Guidelines complement the information in the *Disability Services Policy and Funding Plan*, which includes service specifications, performance measures, data collection requirements and identified standards, policies and guidelines to which service providers must adhere.

Note: The use of the words child or adult, or individual refers to children and adults with a disability and/or high and complex medical or support needs.

The use of the word 'family' refers to the individuals biological or extended family or carers.

¹ Victorian State Disability Plan 2002-2012 (2002) Disability Services Division Victorian Government Department of Human Services Melbourne

2. Goals and Objectives

2.1 Goals

Flexible Support Packages focus on the child or adult with a disability, their family and carers, and aim to:

- Improve quality of life;
- Optimise the capacity of individuals and families to maintain a family environment;
- Facilitate, maintain and enhance independence and reduce the requirement for facility based care;
- Support, develop and enhance existing and new relationships of the child or adult;
- Promote access to community activities and facilities;
- Provide support to families in their caring role;
- Improve options and choices about support and lifestyle requirements;
- Enable proactive intervention and minimise the occurrence of crisis; and
- Promote continuity and integration of support and facilitate long term planning.

2.2 Objectives

Flexible Support Packages assist individuals with disabilities, their families and carers at home by providing planning and flexible supports to meet individual needs.

The objectives of Flexible Support Packages are to:

- Provide short-term assistance to individual and their families that may be experiencing difficulties due to crisis;
- Provide outcome based supports, consisting of a combination of case management and/or discretionary funding to support individuals, their families or carers who require significant assistance. These supports may be discrete episodes, intermittent or be provided over an extended duration;
- Provide timely and accurate information to individuals their families and carers regarding support options in response to the assessed/stated needs;
- Provide information regarding early intervention, developmental issues and life stage milestones to the individual, their family or carers;
- Assist in the area of skill development and facilitate successful transitions through milestones and life stages;
- Support individuals, their families and carers to develop and implement a goal oriented plan which reflects the persons abilities, assessed needs, agreed priorities, and relative duration and intensity of support and services required;
- Work with statewide and regional providers and community groups to minimise duplication and identify service gaps and strategies to improve the responsiveness of the service system to better support individuals with a disability, their families and carers to enable them to remain living in their community; and
- Facilitate opportunities to network with groups in the community to build community capacity and promote community inclusion for individuals receiving a Flexible Support Package.

3. Target Group and Prioritisation

To determine a person's access to the program, three factors need to be considered:

- Is a Flexible Support Package the most appropriate support for the person?
- Is the person in the target group for Flexible Support Packages?
- Is the person a priority for a Flexible Support Packages?

3.1 Target Group

The target groups for Flexible Support Packages are described below.

Children under school age:

Families who have a child under school age with a disability and high support needs including physical, medical, social and emotional needs requiring case management and/or supports additional to those usually available through existing services and/or require a range of co-ordinated services.

Children and young people with high medical needs:

The *Family Choice* component of Flexible Support Packages supports children and young people with high, ongoing medical needs and/or dependence on medical technology. The child or young person, their family or carer would experience difficulty in meeting the high level of ongoing medical care needs in the community if additional support was not provided.

People with a disability:

Children of school age, young people and adults with a disability who meet the criteria specified in the *Intellectually Disabled Persons' Services Act 1986* (IDPSA) or the *Disability Services Act 1991 (including Amendments 1997 & 2000)* (DSA). Children, who prior to school age received a Flexible Support Package, where appropriate are required to have an assessment to determine whether they meet the criteria specified in the IDPSA or the DSA on reaching school age. Previous assessments will be considered including those completed by a DE&T Guidance Officer, doctor or through Regional Disability Services' Intake and Response Team.

People with the type of diagnoses listed below are not in the target group for a Flexible Support Package unless the person also has a disability which meets the criteria in the IDPSA or the DSA.

- People with Attention Deficit and Associated Disorders;
- People with a chronic disease (this incorporates conditions of heart disease, cancer, diabetes, chronic pulmonary disease and chronic liver disease); and
- People with a psychiatric disability ([already picked up above](#)).

The above people's needs may be better served by other program responses.

3.2 Priority of Access

Flexible Support Packages should be allocated according to the relative need of people listed in the target group and further consideration of the following (not in priority order):

- Ageing carers;

- Carers with fragile health and high complex support needs;
- People who require brief and timely intervention to prevent or minimise the need for long term high cost support services;
- People who have high or complex support needs (ie. a range of interacting physical, medical, social and emotional needs and require significant assistance to plan and coordinate a package of services to meet their need/s);
- People who experience significant difficulties in accessing community services and require flexible service responses in terms of the type, duration or timing of assistance that is not available within the mainstream service;
- People who demonstrate significant levels of stress and where the family is at risk of breaking down;
- People whose support needs change rapidly and are at risk of moving to supported residential services;
- Any child or young person living at home who is at high risk of family crisis resulting in non-acute hospitalisation or alternative care arrangement due to the difficulty experienced by the family in continuing to meet the high level of ongoing medical care need at home; and/or
- Any child or young person with high medical care needs at risk of remaining in hospital beyond the need for acute care due to the difficulty the family would experience in meeting the support needs in the family home .

Compensable Individuals

For details about the provision of Disability Services funded services to individuals who have received, expect to receive or are actively seeking compensation to cover the cost of care as a result of accident, injury or illness, refer to 'Compensable Client Guidelines, Department of Human Services Operational Policy Unit (December 2000)'. These can be obtained from the DHS Regional Office or the DHS Disability Services website.

4. Service Description

4.1 Flexible Support Packages

Flexible Support Packages provide case management and/or discretionary funding to families and carers of children, young people and adults with a disability/high and complex medical or support needs.

Case Managers or Family Services Co-ordinators (hereafter referred to as Case Managers) work in partnership with individuals and their families and carers to identify support needs and develop a plan to increase the individual's capacity and family's resilience. Recognition of families and carers as key contributors to the health and well being of the child or adult with a disability is vital. Strong emphasis is placed on a family-centred practice wherever appropriate, which strengthens the capacities of families to care for the child or adult. Further information about family-centred practice is contained in **Appendix 2**.

The Case Manager explores whenever possible, opportunities to use informal supports and to develop, maintain and strengthen relationships with the person and their support network. Importance is also placed on enhancing the interests, talents and abilities of the person. The Case Manager links individuals and families to existing generic services wherever possible, before utilising disability specific services. Supports and services for the individual and family are planned using an integrated and coordinated approach, which reflects both informal and formal supports. Individuals are encouraged to make informed choices regarding services, supports and priorities and be active participants in the community. Assistance can also be directed to building community capacity and inclusion by facilitating links between community groups and the child or adult, their family or carer.

Discretionary funding

Discretionary funds are used for the purchase of services and supports that may not be available from any other source. In most instances a combination of case management and discretionary funding may be required, however it is possible to provide only one of these components.

Service providers are responsible for the development of individually tailored packages of supports, determining case management hours and discretionary funding appropriate to the support needs of service recipients, within the agreed funding and targets outlined in the Service Agreement (SA).

A Family Choice Flexible Support Package has the ability to provide the following additional features:

- Provision of a Homecare Nurse in conjunction with a Case Manager to work in partnership with individuals and families;
- Home based carers, who receive training, monitoring and support tailored to the individuals' ongoing medical care needs; and
- Maintenance of practice standards to individuals and their families by the provision of appropriate documentation, training and ongoing support. This is facilitated by ongoing consultation and the provision of continuing education to Case Managers, Homecare Nurses and home based carers.

4.2 Package Types

Flexible Support Packages offer support to individuals seeking short-term assistance and people requiring intensive or longer-term support. The amount of Short Term Assistance Packages (STAPs) and the amount of Intensive Support Packages (ISPs) will be negotiated with the Regional office annually. The service provider will maintain a "needs register" incorporating demographic information to assist in these negotiations.

Short Term Assistance Packages

STAPs are applicable to Making A Difference Program and Early Choices. They provide assistance to individuals and their families that may be experiencing difficulties due to a crisis situation unit.

A typical STAP is approximately three months in duration. An individual or family/carer may access up to two STAPs per annum.

Individuals in receipt of a STAP who require services beyond that which can be met by a STAP may be referred by the service provider to:

- An Intensive Support Package; and/or
- An alternative support service.

Intensive Support Packages

Intensive Support Packages (ISPs) are applicable to the full range of Flexible Support Packages. There is no time limit for Flexible Support Packages however service providers support the individual and family to enhance their capacity to self manage within the community service system, and thereby increase their independence.

Further information about funding of STAPs and ISPs is contained in **Appendix 3**.

4.3 Key Elements of Flexible Support Packages

The key elements of Flexible Support Packages include:

- Receiving referrals;
- Access;
- Allocation to an appropriate Case Manager;
- Comprehensive Assessment;
- Development of a Support Plan and Expenditure Plan;
- Implementation of the Support Plan;
- Monitoring of the Support Plan;
- Review of the Support Plan; and
- Closure.

4.4 Receiving Referrals

Service providers can receive referrals from a range of sources, including Disability Services, Specialist Children's Services, other service providers, or directly from the individual or family.

A service provider is able to decline a referral if the person is not included in the target group or priority as listed, or if the individual's assessed or stated needs are likely to fall out-side the scope of the program and available funding. When a referral has been declined, a reason for this must be provided together with information regarding grievance procedures (refer to 6.8 of the guidelines). People are encouraged to make a re-referral if their situation changes. Where a child or young person does not meet the criteria for entry to the program the service provider is expected to provide information regarding alternate appropriate supports and services.

Service providers are responsible for the development of a process for the management of a needs register. Where there are multiple providers of Flexible Support Packages across a Region, undefined by geographic area, providers are encouraged to develop a central system. This promotes co-operation between service providers and facilitates equity of access to programs for the individual or family referred across the catchment area.

4.5 Access

Priority of access is determined using the criteria specified in Section 3.2.

Access to a Flexible Support Package depends upon a range of factors including prioritisation of need, package availability, funding available, staffing expertise and availability as well as consideration of prescribed annual targets.

If a child or adult is not considered a priority, the Flexible Support Package service provider is to provide information regarding appropriate alternative supports and services to address the identified or stated needs.

4.6 Allocation

As Flexible Support Packages become available, the service provider will allocate a package to an individual on their needs register and a Case Manager will be allocated to work closely with the individual, their family and carer. The process of allocation of an appropriate Case Manager will take into account a Case Manager's expertise, availability, location and any stated preferences the individual or family may have.

4.7 Assessment

The comprehensive assessment includes a consideration of the social, personal, cultural, spiritual, financial, medical and environmental needs of the individual and the needs of the family. The assessment also takes into consideration the family's values, cultural preferences, lifestyle, informal support networks such as family/friends, access to self-help groups and community networks as well as the immediate environment. In partnership with the individual and others where appropriate, the assessment process identifies the service and support requirements and agreed goals and priorities for the individual.

Integral to the assessment process is the development of a professional relationship with the individual or family/carer with the aim of enhancing individual and family/carer capacity and connectedness with the community. Where possible, the assessment process can be facilitated by the use of existing assessment reports with consent of the individual and/or family to avoid replication of information collection and unnecessary re-assessment.

4.8 Development of a Support Plan

As an outcome of the assessment process, a written support plan will be developed to document agreed priorities and responsibilities. The plan reflects a creative and flexible approach to developing strategies to respond to the person's assessed and stated support needs within the family environment and community context, as appropriate.

In developing a support plan, the Case Manager will consider the following:

- The importance of planning processes being conducted in partnership with the individual and their family and carers as well as relevant others i.e. a service provider;
- The importance of establishing agreed priorities with the individual, their family or carers;
- Goals and strategies identified in the support plan are clear, attainable and measurable and support the needs of the individual, their family or carer;
- The role of the individual and family, professionals and informal support networks in implementing the strategies;
- The process for monitoring and reviewing the support plan and the role of the individual/family/carers in this review process;
- Liaison with service providers regarding priority of access for the individual, their family or carers and secure agreement to commence service provision;
- Access to generic services and community groups as appropriate to meet support needs and build the capacity of individuals and families; and
- The capacity of individuals and families to contribute to the cost of support services.

4.9 Expenditure Plan

Service providers are responsible for the administration of discretionary funding to purchase supports and services on behalf of individuals, their family and carers as identified in the plan. To ensure the provision of discretionary funding is effectively planned and linked to specific objectives, providers must complete an expenditure plan for each individual or family.

An expenditure plan:

- Considers access to existing programs and other relevant services presently operating within the service system;
- Estimates the cost of discretionary funds required to implement the plan recognising the expected duration of the services and one off items /support;
- Considers the individual or family contribution to expenses; and
- Includes the cumulative costs of funds allocated to support the family in the same financial year.

There is no entitlement to discretionary funding. The allocation of discretionary funding is to be based on identified needs, the service provider's assessment of the situation and availability of funding. Service providers are required to have an established system for collecting data regarding the amount of discretionary funding used to support each individual or family. **Appendix 4** details specific requirements related to the use of discretionary funding.

4.10 Implementation of the Support Plan

The implementation of the support plan (including the expenditure plan) will involve:

- Supporting individuals/family/carers as identified in the support plan;
- Continuing to provide information regarding available options;
- Co-ordinating and linking individuals into appropriate services or community groups;
- Advocating on behalf of the person or assisting the person to advocate for themselves;
- Identifying means of strengthening individual and family capacity to manage as independently as possible;
- Identifying local/regional service needs and service gaps and assisting in broader service planning and development to better respond to these needs; and
- Working with the community to establish informal and formal support networks for individuals and families.

4.11 Monitoring

Monitoring provides the opportunity to ensure that the person or family is satisfied with the support plan and its progression towards the agreed goals. It is also a mechanism to ensure the support plan addresses agreed goals. Monitoring of the support plan is conducted in partnership with the individual and family and may also involve relevant others as outlined in the support plan. The monitoring process will rely on mutual feedback that will vary in intensity dependant upon the implementation stage of the support plan. Amendments can be made to the support plan at any stage to reflect changes in support needs/goals.

4.12 Review of Plan

Formal reviews will be held at agreed periods in partnership with the person or family. As a minimum requirement, support plans should be reviewed every six months. At the time of the review the Expenditure Plan is also reviewed and altered to reflect changes. This formal review and reassessment of progress will be clearly documented and copies forwarded to the individual or family as appropriate.

The purpose of the formal review is to ensure that supports are meeting identified needs.

4.13 Closure

Closure is considered when the person or family no longer require support provided through the Flexible Support Package or the stated objectives of the support plan are reached.

Closure may occur because:

- The individual or family have achieved the goals;
- The individual, their family or carer request to exit the service;
- The individual enters into an alternative living arrangement;
- The individual/family/carers moves to another service; and
- Death of the individual.

Tasks related to closure:

- Advising the individual, their family or carer to recontact the agency in the event assistance is required in the future;
- Establishing transition arrangements with the individual, their family or carer;
- Providing transitional support to the individual in the event move to a supported residential option;
- Completing appropriate administration requirements, including finalising discretionary funding payments and closing files; and
- Notifying the relevant DHS regional office.

5. Quality

5.1 Standards

Support providers who receive Disability Services' funding totalling \$20,000 or more, are required to comply with Victorian Standards for Disability Services (VSDS) and other service standards and guidelines listed in their Service Agreement. The VSDS are the minimum operating requirements for government and funded support providers delivering disability services in Victoria. Support providers working with children under school age must comply with the Specialist Children's Service Program Standards. Copies of standards and guidelines can be obtained from DHS Regional Offices or the DHS Website http://hnb.dhs.vic.gov.au/ds/disabilitysite.nsf/pages/prov_quality_standards.

5.2 Monitoring against Standards

Disability Services manages a process for external independent verification of support provider compliance with the VSDS.

DHS recognises the use of a number of alternative self-assessment approaches. The use of alternative approaches must be negotiated with Disability Services. Further information about alternative approaches is contained in the DSAS.

6. Practice Guidelines

6.1 Transition and Relocation

Transition is the planning process to assist individuals or families move from one support provider to another with the least disruption to their ongoing support needs. This can occur in areas where a person is required to move to another program when they reach a certain age or when the individual or family plan to relocate. Planning for this and providing as much notice as possible to the new support provider is important to a successful transition.

6.1.1 Transition and Relocation Process

Where an individual or family requires transition or relocation within Victoria, support providers work together to ensure that ongoing support requirements are maintained. In planning a transition or relocation support providers should consider the following:

- Ensure continuity of care wherever possible;
- Minimise duplication in processes such as assessment (with permission for exchange of confidential information);
- Provide as much notice as possible to the new support provider of an impending transition. In instances where relocation occurs, only a few months notice may be possible, however, where the transition is age or life stage related as much as 12 months notice is possible;
- Convening a transition planning meeting between the individual and family (as appropriate), the current support provider and proposed support provider. At this meeting transition arrangements and continuing support arrangements are discussed and formulated into a transition plan. This plan outlines the process for transition, responsibilities, timeframes and the proposal for continuation of support;
- In the event the new provider is unable to provide support and funds to the family immediately, the referring program continues to support and meet associated costs until the new provider has allocated resources to the family;
- Allocate a package with the new service provider as soon as one becomes available and therefore the transition arrangements remain in place for a few months and do not exceed one year; and
- Use funds from the referring program only to meet discretionary expenditure if appropriate and necessary. The new support provider provides the case management component (if required) upon transfer.

6.1.2 Alternatives to Transition

Occasionally, individuals or families may prefer to receive supports from a different region to that in, which they reside. As a general principle Flexible Support Package service providers work within their regional boundaries, however, for some individuals or families an interim or ongoing support arrangement negotiated with the relevant Regional DHS offices and providers may provide greater continuity of support.

The alignment of *Early Choices*, *Family Choice*, *Continuity of Care* and *Making a Difference* programs provides scope for a support provider that auspices only one of these programs to offer continued support provision at transition points. For example, a family may prefer to continue with an *Early Choices* Flexible Support Package service provider rather than transferring to a service provider of *Making a Difference* Flexible Support Package as their child makes the transition from pre-school to school. In this

case, support providers negotiate with the DHS Regional office and another support provider to exchange targets and associated funding allocation in order to retain greater consistency of supports. This ensures continuity of support and long term planning for the child or adult with a disability and their family.

This process of negotiation can occur with the agreement of all providers and DHS Regional Office at the commencement of, or during the financial year. At all times the total age-related targets allocated across a Region maintained.

6.2 Promoting Partnerships

Flexible Support Package providers should work with other providers, DHS and relevant statewide organisations to:

- Facilitate a spirit of cooperation that will result in better access and more effective delivery of supports for individuals, their families and carers;
- Inform other support providers about the special needs of children, young people and adults, their families and carers;
- Promote better integration of formal and informal supports;
- Identify ways to enhance existing supports;
- Consider new and innovative ways of providing supports; and
- Build capacity with the community.

Flexible Support Package providers should develop protocols with programs and agencies such as Specialist Children's Services teams, Early Intervention providers and Special Developmental Schools. This will facilitate smooth transitions, minimise waiting periods, and confirm review periods and operating guidelines in an endeavour to improve outcomes for people receiving support.

Protocols relate to the provision of information about program aims, eligibility criteria, priority, service requirements and referral protocols and communication channels to assist individuals, families and carers in continuity of support provision.

6.3 Multi-Source Support

There are a significant number of Flexible Support Package support providers auspicing similar programs such as Linkages and HomeFirst. In these instances or where DHS Disability Services or Specialist Children's Services teams are involved, it is generally agreed that a single Case Manager will be involved. When two Case Managers are involved, it can lead to confusion regarding roles and responsibilities and duplication of services. At the commencement of support, all organisations confirm the involvement of other service providers and where necessary, clarify roles and advise who will undertake the lead case management role.

6.4 Best Practice Principles (for Children with Disabilities & Complex Care Needs)

In 1995, DHS endorsed best practice principles for children with disabilities and complex support needs. These principles are set out in **Appendix 5**. Service providers are required to operate in a manner consistent with these principles when working with families with children with disabilities and complex support needs.

6.5 Permanency Planning Principles

Flexible Support Packages support the practical application of the principles of Permanency Planning, which underpin the delivery of child, young person and family disability services in Victoria. These principles are set out in **Appendix 6**.

A Flexible Support Package aims to maintain the existing care arrangements and to prevent out of home placement. Where a family indicates they are seeking out-of-home placement, support providers work with the appropriate DHS regional staff to assist the family in planning the most appropriate option to meet the child's social, emotional and developmental needs. The family continues to receive support from the Flexible Support Package until clear transition arrangements are in place.

6.6 Shared Care Arrangements

In situations where a child or young person is spending a significant amount of time with both a care-giver family arranged through the *Family Options* Program and their birth family, responsibility for case management and financial support for both families should be clarified. **Appendix 7** details issues to be considered in these circumstances.

6.7 Grievances

General principles:

- The right of an individual to lodge a complaint about support is fundamental in Disability Service's strategy to promote the rights and responsibilities of people with a disability.
- Both support providers and regional DHS offices must have policies to inform individuals of their right to complain, and procedures to resolve any complaints received in a format which they can understand and which is easily accessible.
- Individuals in receipt of support through the program are entitled to have complaints investigated objectively, fairly, promptly and without fear of retribution.
- Complaints may also inform access/service delivery practices, with a view to improving the support.

If the support provider is unable to resolve the grievance to the satisfaction of the individual or their family, the support provider should provide written details of a contact person at the Regional DHS Office, who will negotiate a resolution to the complaint. At each stage, the person who has issued the complaint or grievance, will be offered an advocate and/or an interpreter should one be required. The support provider is generally responsible for funding the cost of the interpreting service. A written report is to be forwarded to all relevant parties involved in the grievance or complaint at the conclusion of the process.

Where the grievance is with DHS, existing internal DHS regional grievance procedures must be followed. These procedures must be made available upon commencement of DHS funded services in a format that is appropriate to, and understood by, that person.

DHS Regions should also ensure that other avenues, for example advocacy, for dispute resolution are made available to the person or their family.

6.8 Privacy

The Health Records Act 2002 establishes the privacy standards for the handling of health and client information. There are also provisions in the *Intellectually Disabled*

Persons Services Act 1986 that protect the confidentiality of people's information. Further details in relation to privacy are available at www.dhs.vic.gov.au/privacy

6.9 Statewide Services

The *Family Choice* and *Continuity of Care* programs have a statewide focus and contract out the case management component of packages to regionally based support providers. These programs are centrally co-ordinated by the auspice agency and the contracted support provider facilitates service provision.

6.10 Insurance

DHS is responsible for and funds insurance coverage for certain Community Service Organisations and/or kindergartens funded by DHS. For further information of this insurance please see *Department of Human Services Insurance Guide for Non-Government Organisations 2001-2002*. Refer to Appendix 9-Glossary of Terms.

Appendix 1

Description of Individual Programs

Early Choices Program

The *Early Choices Program*, funded through the Community Care Division, provides flexible respite and support to families who have a child with a severe disability and high support needs, from birth to school entry age.

Services are tailored to meet the particular needs of each family and may include:

- Family Services Co-ordination;
- Provision of a paid carer to provide respite to allow parents a break;
- Training to enable paid carers to attend to the special needs of the child;
- Equipment to help the child where that equipment was unable to be funded elsewhere; and
- Other options identified in partnership with the family to enable them to care for their child at home.

Family Choice Program

The *Family Choice Program* is a joint statewide initiative of the Community Care, Disability Services and Metropolitan Health and Aged Care Divisions. The program provides home based support to families of children and young people, with high ongoing medical needs and/or dependence on medical technology. The program promotes the social, physical and cognitive developmental needs of the young child or young person within the context of the family. Families, children and young people are involved in care and support planning and in making informed choices. The objectives of the program are:

- To enable children and young people with high needs and/or dependence on medical technology to live with their families;
- To reduce the length of stay in hospital and the use of emergency services by children and young people with high support needs and /or dependence on medical technology; and
- To maintain or enhance the quality of life of children and young people with high needs and /or dependence on medical technology.

Continuity of Care Program

The *Continuity of Care* program was established in January 1996 and aims to support families caring for a child or a young person with severe and/or multiple disabilities. The program is available to individuals with sensory, intellectual disability or acquired brain injury defined under the Disability Services Act (insert year of publication). The program aims to support families to continue to care for their child in the family home.

Families are supported with case management and discretionary funds to access a range of flexible programs. The capacity for the *Continuity of Care* program to provide case management is limited. In practice many families receive case management from a *Making a Difference* program support provider and *Continuity of Care* provides the discretionary funding.

Making a Difference Program

The Making a Difference Program, funded by Disability Services, provides a combination of case management and discretionary funding to flexibly meet additional high support needs of children with disabilities, their families and carers. *Making a Difference* aims to support families caring for individuals over 6 years of age or older with moderate, severe and profound disabilities and high support needs. The program aims to support people who live in the family home.

Appendix 2

Family Centred Practice

Flexible Support Packages operate with a family centred practice approach.

This approach focuses on the family as the integral player in decision-making, where families are involved in a mutually respectful, collaborative working partnership with support providers. Families are provided with information and support that assist them in decision-making processes.

Family centred practice involves a partnership between service providers and each family in ways that:

- Promote, support and adapt to the style, needs, aspirations and priorities of the family;
- Support parents in making informed decisions, and in determining services and their levels of participation;
- Strengthen the family's ability to obtain and use formal and informal community resources that enhance well-being, parenting and child development;
- Emphasise and build on family strengths and abilities;
- Share ideas, knowledge, skills and strategies between parents and professionals to promote interactions and activities that enhance the child's competencies and development;
- Support generic services and community programs that parents choose for their child;
- Provide opportunities for families to give as well as receive assistance; and
- Nurture and support networks that allow families with similar experiences to share ideas, concerns, aspirations and support.

An integral component of family centred practice is the development, in conjunction with the family, of a Family Support Plan. The plan reflects the shared ideas, knowledge, skills and strategies of parents and professionals in relation to the provision of appropriate services, the ongoing development of the child and support for the family.

Appendix 3

Funding and Targets

Funding

Service Agreements provide the basis for payments to agencies and include details on the annual funding and targets for each support provider. Support providers are encouraged to refer to the current Disability Services' Policy and Funding Plan for further information on funding detailed in the Flexible Support Packages Activity Specification.

The funding allocations of *Making a Difference* Flexible Support Package service providers are divided between case management and discretionary funding as per the following formula:

- A maximum of 37% of the total Making a Difference Flexible Support Package funding is dedicated to case management contact hours;
- A minimum of 63% of the total Making a Difference Flexible Support Package funds is dedicated to discretionary funds. Service providers may use up to 12.5% of this allocation for the administration of the discretionary funds. The costs of administration must be documented and made available on request; and
- Making a Difference Flexible Support Package service providers may negotiate with the Regional DHS Office to utilise the administration component of the discretionary funds for additional case management hours.

Regional Targets

DHS Regional targets are established based on the following:

- Two Short Term Assistance Packages STAPs equate to the average funding of one Intensive Support Package;
- A notional 20% of funding is dedicated to STAPs; and
- A notional 80% of funding is dedicated to Intensive Support Packages (ISPs).

The breakdown of funding and targets is negotiated on an annual basis between service providers and the DHS Regional office.

A Flexible Support Package target is counted as the individual who meets the criteria of the target group and priority. For example, if a family in receipt of a Flexible Support Package has two individuals who fit the target group and priority they are counted as two Flexible Support Package targets.

For both STAPs and ISPs, the resources provided to an individual/family are allocated on the basis of assessed need determined by the service provider within the global funding and targets outlined in the FASA.

STAPs do not apply to Family Choice or Continuity of Care.

Appendix 4

Discretionary Funding

Support providers should work with individuals or families to formulate a plan that provides relative case management hours and discretionary funding appropriate to the specific needs of the individual or family. There is no set allocation or specific entitlement of case management hours or discretionary funding per individual or family.

Support providers are accountable for and required to balance the distribution of case management hours and discretionary funding within the total Flexible Support Package funds outlined in the Service Agreement.

All individual families in receipt of discretionary funding must have an expenditure plan. The use of discretionary funding is integrated and coordinated to meet the goals of the Flexible Support Package, developed in partnership with the individual and/or family and carers.

The use of discretionary funding is not prescribed, however, the following issues are considered:

- The individual circumstances of the person with a disability;
- Likelihood of achieving the identified outcomes for the person with a disability, their family and carers;
- The planned and coordinated use of funds;
- The likes and dislikes, skills, talents and interests of the person with a disability;
- Existing informal supports and the development of informal supports over time;
- Enhancing the opportunity for the person with a disability to participate in the life of the community;
- Enhancing the opportunities for the person with a disability to develop, strengthen or maintain relationships;
- The use of generic supports;
- Maximising contributions from other sources;
- The effectiveness of funds previously used for a similar or related purpose;
- Maximising the value of the funds;
- Minimising duplication of services;
- Facilitating continuity of care;
- Enhancing the quality of service provision;
- Maximising the autonomy and choice of the individual and family and carers;
- Flexibility in meeting the stated needs; and
- Addressing barriers to realising the aspirations of the person with a disability.

In relation to the use of discretionary funding for continence aids, aids and equipment, capital grants and behaviour management the following specific guidelines apply:

Aids and Equipment

When using discretionary funding to purchase aids and equipment it is the responsibility of Flexible Support Package service providers to ensure that:

- The equipment has been prescribed by a suitably qualified health professional;
- The equipment has been purchased in a cost-effective manner; and
- Training in the use of the equipment is provided.
- The Victorian *Aids and Equipment Program*

The Victorian Aids and Equipment Program (A&EP) provides funding for equipment specified in the A&EP Guidelines in the list of 'Aids Available'. The A&EP coordinators are able to provide advice and support to service providers when considering the purchase of any of the aids or equipment on the list.

Children and adults who are eligible for a Flexible Support Package may also be eligible for the A&EP. Whenever possible the A&EP is the first avenue of equipment supply. The A&EP Guidelines provide details about eligibility, subsidy levels and the application process. In addition to providing the subsidy, the A&EP will assume the responsibilities outlined above. The A&EP will also assist in the following ways:

- The review of applications, which ensures that all options for person with a disability are considered;
- Reduced costs to service providers and families as a result of re-using equipment, the contribution of the A&EP to the cost of the equipment and the purchasing capacity of A&EP;
- A&EP has responsibility for repairs; and
- A&EP tracks equipment to ensure its retrieval when it is no longer required, assumes the costs of equipment storage and ensures its re-use where possible.

Use of Flexible Support Package discretionary funds

When equipment is considered to be a priority for the person with a disability, family or carer and the prescribing health professional, a Flexible Support Package service provider considers:

- Purchasing the equipment if it is not on the A&EP list of 'Aids Available';
- Contributing to the cost if the A&EP subsidy does not cover the total cost of the equipment; and
- Purchasing the equipment if the A&EP is not able to arrange its supply in a timely manner due to demand on the program. In this instance the Flexible Support Package service providers are expected to use A&EP as a conduit for the purchase and supply of the equipment. It is not expected that purchase occur via the A&EP if it costs more to do so than purchasing the equipment through other means.

Second-hand equipment

Second hand equipment can only be purchased using Flexible Support Package discretionary funds when:

- The second hand equipment has been prescribed by a suitably qualified health professional; and
- The equipment supplier or repairer can certify the quality of the equipment.

Ownership

When a Flexible Support Package service provider purchases outside of the A&EP new or second-hand equipment, which is on the list of 'Aids Available', the details of the

equipment are forwarded (with the consent of the individual or family) to the A&EP so ownership can be registered.

Wherever possible, Flexible Support Package service providers seek to have ownership of equipment rest with the A&EP. The A&EP will then provide tracking and repair of the equipment, and will arrange for its return and reallocation as part of the wider equipment pool.

If an organisation **not funded by DHS** or an individual contributes more than half of the cost of the equipment, the organisation or individual has ownership of the equipment and the responsibility for repairs. Alternatively the organisation or individual can elect for the equipment to be owned by the A&EP.

Continence Aids

Prior to the purchase of continence aids for anyone aged over four years, it is recommended that a continence assessment by a qualified continence specialist be undertaken. The continence assessment outlines the nature of any intervention, the details of recommended continence aids and a date for review. Flexible Support Package service providers support the outcomes of the assessment wherever possible.

Where the individual or family has determined continence as a priority need, it is possible for Flexible Support Package discretionary funds to be used to purchase continence aids, including topping up of continence aids acquired through the A&EP, Continence Support Services or Continence Aids Assistance Scheme funding.

Capital Grants

A capital grant is non-recurrent funding used for expenditure on properties such as home modifications, renovations or extensions. When discretionary funding is used as a capital grant service providers must consider the following:

- Grants are only made following a careful appraisal of the likely stability of the living arrangements;
- Grants may cover the whole or part of the costs. For example, it may be appropriate in some instances for the family to contribute part of the cost;
- All building works must comply with the Building Code of Australia and have a Local Government Authority (LGA) building permit issued by the local responsible authority. It is advised that the LGA be contacted in regard to the need for a planning permit;
- Home modifications have been prescribed/assessed by a suitably qualified therapist to ensure they address the individual's support needs and that they comply with Australian Standards;
- Archicentre's Home Renovations Service provides free architectural assessments of the homes of people with a disability. The Service is consulted following an assessment by a suitably qualified therapist and prior to obtaining a quote from a builder. This service includes sketch drawings but does not include working diagrams. Working diagrams may be required to comply with the Domestic Building Contracts Act 1995; and
- Payment of claims for building works is on a progress certificate basis and after an inspection of the property to ensure the works are completed.

Where a capital grant is:

- Less than or equal to \$50,000 the discretionary funding is conditional on the expectation that the living arrangements will continue for at least four years. If

the person with a disability moves from the residence within four years, repayment of discretionary funding is expected less 25% of the grant for each year that the person lived there. In the event of the death of the person there will be no liability for repayment;

- More than \$50,000 the discretionary funding is conditional on the expectation that the living arrangements will continue for at least eight years. If the person with a disability moves from the residence within eight years, repayment of discretionary funding is expected less 12.5% of the grant for each year that the person lived there. In the event of the death of the person there will be no liability for repayment; and
- Where a capital grant is more than \$50,000, service providers must develop a process, which supports the service provider's claim of financial interest in the property and the lodgement of a caveat on the Certificate of Title. This is achieved by developing a Deed of Agreement between the service provider and the property owner similar to the example in Attachment 1.

Behaviour Intervention

When considering the use of discretionary funding for the purchase of behaviour intervention, the following must be considered:

- A behaviour management specialist (such as Early Childhood Intervention Services, Behaviour Intervention Support Team or other specialist) has been consulted in the development of the behaviour intervention;
- Any previous behaviour intervention and the outcomes of those interventions;
- Reactive short-term strategies for de-escalating behaviour are complemented by proactive long-term strategies which relate to skill development;
- The behaviour intervention strategies are only a part of a holistic plan which recognises the context within which the behaviour occurs;
- The need to plan for transition support with the withdrawal of behaviour intervention, such as training of family members, carers or any modifications required; and
- Review of the behaviour intervention is planned and the outcomes of the review inform further planning.

Appendix 5

Best Practice Principles (Children aged 0-18 with Disabilities & Complex Support Needs)

1. Children with complex support needs require a service system that promotes the *individual* child's social, emotional and cognitive development within the context of his or her family.
2. The service system resources and supports the parents as primary care givers. (It is acknowledged that the parents and child's needs are not always congruent.)
3. The services are adequate and flexible.
4. The services are planned, appropriate, responsive and reliable in order to meet the particular needs of the child and the family.
5. Information on all available and relevant services is provided to enable consumers to make informed choices.
6. Services to the individual child and family are coordinated and integrated to minimise the number of different service providers involved in the care planning and service provision.
7. The service system is child and family focused not agency focused for example, assessment and the provision of care is based on the individual child's need, not the tasks to be performed or the services currently provided by the agency. The service system provides carers who receive appropriate training and ongoing monitoring.
8. The continuity of carers is a priority.
9. Children with complex support needs are able to move through the service system due to changes in need, age or geographic location without experiencing interruption to the provision of services.

Appendix 6

Permanency Planning Principles

Permanency planning is care planning which is aimed at ensuring that a child with a disability:

- Has a consistent, enduring relationship with an adult/s whose status as the primary care giver/s is clear to the child and who has/have a commitment to nurturing and advocating on the child's behalf until the child reaches adulthood; and
- Lives in a family environment throughout childhood.

In the first instance, every effort is made to support the birth family in caring for the child at home. If this proves not to be feasible, a placement is sought with another family, which undertakes to care for the child until adulthood. The core rationale for permanency planning lies in the notion that all children need the emotional security of a continuous and positive bond with an adult/s who nurtures and advocates on the child's behalf until adulthood. The centrality of this bond facilitates the child's growth in competence in exploring and interacting with the physical and social environment in which he/she lives, including emotional growth.

Permanency planning practice requires families to be engaged in a process of planning for the child's future that includes:

- Identifying situations where a child may be at risk of being placed away from home either currently or in the future and taking strategic intervention to either prevent the need for placement or to facilitate a referral for family placement if placement cannot be prevented;
- Resolution of uncertainty about the child's future placement within a time frame, in order to minimise the risk of the child becoming emotionally insecure;
- Understanding that while temporary respite or foster care can help the birth family replenish, that long term out of home stays allows the family to re-organise itself to the exclusion of the absent child and can lead to the child 'drifting' in care;
- Facilitating and supporting the family in identifying their own priority needs which have to be addressed if the goal of keeping the child in a family environment is to be achieved;
- Sensitivity to the quality of bonding and attachment between parents and child, any impediments to this and how such impediments may be addressed;
- Minimising the number of caregivers in a child's life;
- Awareness of and if necessary addressing total family needs, not simply those related to the child's placement;
- Ensuring that birth families (and also substitute families) have access to whatever information and skills they may need in caring for the child at home;
- Clarification of legal guardianship and custody responsibilities if a child is being placed away from home; and
- Actively encouraging families who have made a decision to place their child away from home to consider the family placement option and the importance of a stable family experience for the child's development; while also responding to any concerns and queries the birth family may have about family placement and facilitating resolution of any ambivalence.

Appendix 7

Shared Care Arrangements

Issues To Be Considered When A Child Is Receiving Care From Their Birth Family And Family Options.

In 'Shared Care' situations where the child is spending a significant amount of time with both the caregiver family and the birth family - e.g. half time with each, or one third time with one family and two-thirds with the other - the issue of the respective responsibilities of Flexible Support Packages and the *Family Options* support provider, for case management and financial support to both families, may arise.

As a general principle, if Flexible Support Packages or *Family Options* support providers are spending a significant amount of time with both the caregiver family and the birth family, the responsibility for case management and financial support for both families will rest with the *Family Options* service.

Where a Flexible Support Package provider has already been supporting the birth family with case management and discretionary funding, the responsibilities for these functions after placement of the child with a caregiver, will be determined on a case by case basis by Flexible Support Packages and *Family Options*. Factors to consider in making the decision include:

- Family preference;
- Likely impact of changing Case Managers at a particular point in time;
- Focus or primary objectives of case management at the time, and whether these are more related to Flexible Support Packages or family placement functions; and
- Whether sufficient funds are available through the Family Options service to support both families.

Where both services remain involved, it is essential to have close cooperation and coordination between the two services, with jointly developed, documented roles and responsibilities and support plans. There also needs to be a clear understanding between the service providers involved as to which service provider has the lead role and for what period of time. These arrangements need to be clearly communicated to both the birth family and the caregivers. Similar principles apply to children who are receiving case management services from DHS regional Disability Client Services.

Appendix 8

Privacy

Background and Context

Disability Services is committed to protecting the confidentiality of people's personal information. There are provisions in the *Intellectually Disabled Persons Services Act 1986* (IDPSA) that protect the confidentiality of people's information. There are also a number of acts that regulate the handling and management of information. These are the *Information Privacy Act 2000* (Vic) and the *Health Records Act 2001* (Vic) and the *Information Privacy Act 1988* (Commonwealth).

Under the *Health Records Act 2001*, (HRA) the definition of health information includes disability information. Therefore, information management practices relating to a person's disability may be governed by both the HRA and the IDPSA.

The confidentiality and privacy of individual information is essential to both individuals and service providers. Privacy and confidentiality enable individuals to trust service providers when discussing sensitive and personal matters, thereby facilitating appropriate service provision and support.

Privacy legislation:

- Seeks to provide safeguards in relation to the use and disclosure of personal and health information;
- Complements and promotes good business practices and seeks to give individuals control over how their personal and health information is used and shared;
- Protects personal and health information through its entire life cycle — from collection to destruction;
- Ensures that services only use personal and health information for authorised purposes and protects personal and health information from misuse and unauthorised disclosure; and
- Provides individuals with a mechanism for gaining access to their personal and health information.

The Intellectually Disabled Persons Services Act (IDPSA) 1986:

- A person who provides or has provided services under the IDPSA is bound by the confidentiality provisions under that Act;
- The Act specifies that direct or indirect disclosure of information regarding a person who is eligible or who may be eligible is not permitted unless it is with the consent of the person or it is reasonably required to provide a service. (For further detailed information read section 16 of the Act); and
- The provisions of the IDPSA are more stringent than the principles in the Health Records Act (HRA), and in the event of any inconsistency, the IDPSA prevails.

The Health Records Act (HRA) 2001:

- The HRA, which came into effect on July 2002, aims to protect the privacy of an individual's health information (including disability information) and allow individuals greater control over how this information is managed;
- The HRA applies to the Victorian Government sector, Victorian Government funded health and disability services, private health and disability services within Victoria and any other organisations within Victoria that hold health and disability information;
- Health information that is collected, held or used by organisations must be handled in accordance with the Health Privacy Principles in Schedule 1 of the HRA;
- The Health Services Commissioner will have governance of matters relating to compliance with the HRA; and
- Any Guidelines issued by the Health Services Commissioner in relation to information handling will also be binding.

Telling individuals about information privacy

- Under the HRA, any entity in Victoria that holds identifying health (including disability) or personal information must make available to individuals, on request, a written statement outlining their information handling practices and how individuals can seek access to their health records; and
- Reasonable steps must be taken to ensure that individuals are notified of their rights prior to the collection of the health or disability information.

For more information about privacy, you can refer to:

The Department of Human Services
www.dhs.vic.gov.au/privacy

The Health Services Commissioner
www.health.vic.gov.au/hsc/

The Privacy Commissioner for Victoria
www.privacy.vic.gov.au

The Commonwealth Privacy Commissioner
www.privacy.vic.gov.au

For information about legislation, you can refer to the Victorian Government's Legislation and Parliamentary Documents Web page, which can be found at:
<http://www.dms.dpc.vic.gov.au/>

Appendix 9

Glossary of Terms

Terminology	Description
Assessment	The process of gathering and sharing information about the needs and abilities of the individual together with the needs, resources and priorities of the family (where appropriate). The assessment is to assist in making informed decisions for the purpose of planning programs and supports as well as use of services.
Carer	A carer is usually a family member who provides care and support to children or adults with a disability, chronic or mental illness or who is frail aged. Carers provide emotional and practical support, which can range from an hour or two per week to full-time care. A carer may be a family member, significant other, friend or neighbour.
Case Management	The provision of information, referral, ongoing assessment, development and implementation of a plan, monitoring, review and advocacy.
Case Manager	The worker nominated by a provider to work in partnership with the individual or family to provide case management. A Case Manager may also be known as a Family Support Co-ordinator.
Disability	See: Legislation See: Severe Disability
Discretionary Funds	Component of funding used flexibly to purchase supports or services for an individual or family.
Early intervention	Services and support for children with disability and/or developmental delay, and their families, prior to school entry.
Family Centred Practice	An approach to service delivery where families are involved in a mutually respectful, collaborative working partnership with services providers and are provided with information and support, enabling them to make informed decisions about their child. See Appendix 2.
Family Service and Support Plan	A plan developed for the child and the family to address specific needs identified by parents and professionals in the assessment phase. The plan will include strategies to achieve specific goals and outcomes for the child and family. A review date is always included in the plan, which does not exceed six months. The breadth of the plan will vary depending on the needs of the family and the child. See 'Plan' also.
Generic Service	A service available to the general community such as Community Health Centres, Child Care Centres, Maternal and Child Health Services, Preschools and General Practitioners.

Terminology	Description
High level of ongoing Medical Care need	<p>The need for daily home based medical care which:</p> <ul style="list-style-type: none"> ▪ Occurs frequently during the day or night; ▪ Takes a prolonged period of time to complete (eg. slow gastro feeds); ▪ Involves a range of organ systems (eg. tracheotomy care, gastrostomy feeding and procedures for managing fitting); <p>and/or</p> <ul style="list-style-type: none"> ▪ Occurs on an irregular basis during a 24-hour period.
Intensive Assistance Package (ISP)	<p>Intensive Support Packages are for people with complex care needs who require significant support to plan and co-ordinate a range of services to meet additional needs.</p>
Legislation Providers are required to access a copy of each relevant Act.	<p><i>The Intellectually Disabled Person's Services (IDPS) Act 1986</i> The IDPS Act is the Act that empowers DHS to fulfil its functions and responsibilities to people with an intellectual disability. Its purpose is to ensure that a range of services is planned and developed around the needs of people with an intellectual disability. A person may be declared 'eligible' for services under the IDPS Act if they are over the age of five years and are assessed as being intellectually disabled or under six years of age and are assessed as being developmentally delayed.</p> <p><i>Disability Services Act (1991)</i> The Disability Services Act (DS Act) provides for the delivery of services to people with 'intellectual, psychiatric sensory or physical impairments or a combination of those impairments'. The Act enables the funding of non-government service providers, and contains schedules outlining objects, principles and objectives to be taken into account.</p> <p>Note: People whose primary impairment (disability) is assessed as being psychiatric may receive services under the Mental Health Act 1986.</p>
Plan	<p>Also referred to as care plan, case plan and Family Service and Support Plan. A plan is a document that sets out the agreed goals; the strategies to meet the goals; identifies who is responsible for the strategies; the costs involved; and specifies a date when the plan will be reviewed.</p>
Review	<p>A formal process undertaken in partnership with an individual or family to examine progress made towards attaining the goals, and to develop a new plan.</p>

Terminology	Description
Severe Disability	<p>A significant and long term functional limitation in one or more of the following areas of development:</p> <ul style="list-style-type: none"> ▪ Receptive and expressive language; ▪ Cognitive development; ▪ Fine and gross motor development; ▪ Self care and independence skills; ▪ Behaviour; ▪ Social development; <p>and</p> <p>When it can be demonstrated that the child/has at least one of the following:</p> <ul style="list-style-type: none"> ▪ Is at significant risk of serious injury to self or others; ▪ Is extremely restricted in their capacity for movement; ▪ Has exceptional support needs.
Short Term Assistance Package (STAPs)	<p>A Short Term Assistance Packages is suited to an individual or family who have the capacity to self manage, but require one off or intermittent support to address a specific need or overcome a short-term crisis. A STAP is of approximately three months duration.</p>
Specialist Children's Services	<p>Services providing early intervention and support for a child with additional needs and their families.</p>