NDIS access process for people with psychosocial disability

The Evidence of psychosocial disability form is the preferred way for people with a psychosocial disability to provide evidence of disability when applying to access the NDIS.

The form was developed by the Transition Support Project at Flinders University in collaboration with the NDIA, and was originally developed for participants of Commonwealth funded mental health programs that were transitioning into the NDIS. The form has been publicly available on the NDIS website since October 2019.

This fact sheet is a guide to using the 'Evidence of psychosocial disability' form as part of the access process. Please be aware that the evidence you share with the NDIS and how you present it may affect the NDIS's decision; therefore, you should inform yourself more broadly about how to put together a strong NDIS application. Do not rely on this fact sheet alone.

At a minimum, if you are providing evidence to support a person's NDIS access request, or supporting them to gather evidence, we recommend completing our free NDIS access and psychosocial disability online training module (or the alternate version for clinicians), reading the NDIA's 'Access Snapshots 1-6' and familiarising yourself with other resources at www.tspforall.com.au. You can also contact your Local Area Coordinator for access information or support.

How to use the Evidence of psychosocial disability form

The Evidence of psychosocial disability form has been designed to address the disability criteria that a person must meet to demonstrate they meet the access criteria for the NDIS. It does not provide information about age, residency or consent to apply, so it must be completed with either of the following options depending on the person's preferences.

Option 1: Access Request Form + Evidence of psychosocial disability form

- Download and complete relevant sections of the Access Request Form (ARF)
    - Complete all of Section 1 (information about the applicant)
    - Section 2, parts A and G (information about the treating clinician)
    - Section 2, part B, questions 1 and 2 (listing the applicant's disability – more detailed disability evidence will be provided elsewhere)
    - *If there is only a psychosocial disability,* leave the rest of section 2 blank
    - *If there is a co-occurring disability,* use section 2 to provide information on that disability
- Download and complete the Evidence of psychosocial disability form.
- Send both forms to the NDIA, along with any other evidence and/or consent forms.

Option 2: Verbal Access Request + Evidence of psychosocial disability form

- Call the NDIA and ask to complete a verbal access request (VAR). The applicant must be present and willing to speak to the NDIA to begin this process.
- Make a note of the person's NDIA reference number which will be provided during the call.
- Download and complete the Evidence of psychosocial disability form.
- Send the completed Evidence of psychosocial disability form to the NDIA, along with any other evidence/consent forms, within the timeframe specified by the NDIA when completing the VAR.

Who can complete the Evidence of psychosocial disability form?

The form needs to be completed by an appropriately qualified mental health professional, or professionals, who can provide information about a person's clinical history and daily function.

Section A: Clinical Information

Section A gathers information about:

- diagnosis or presentation of the mental health condition(s)
- hospitalisations related to mental health condition(s) if applicable
- past and current treatments for the mental health condition(s) (pharmacological and non-pharmacological)
- likely outcomes of ongoing and future treatments in terms of clinical recovery
- daily function as it relates to the person's psychosocial disability (only required if question 6 in Part B is not completed by a separate mental health professional).

Section A must be completed by an appropriately qualified clinician who has been involved in, or has access to, the person's treatment history. Generally, this would be the person's GP or psychiatrist; however, this may vary depending on the person's circumstances and their treatment team.

Section B: Functional information

Section B gathers information about:

- functional capacity as determined by the Life Skills Profile 16 functional assessment tool
- how a person is impacted by their impairments for the relevant NDIS life domains.

Section B should be completed by a mental health professional who knows the person well and can provide information about the impact of the person's mental health impairments on their life. This could be a support worker, allied health professional or a clinician (including the clinician who completed Section A). Completion of the online LSP16 functional assessment tool training is required to provide information in Section B.

If Section B has been completed by a separate person, the level of detail required by the clinician completing Section A is reduced. In this situation, we recommend completing Section B prior to asking a clinician to complete Section A. If the form is completed by a single clinician, they will need to complete the relevant parts of Section A and B.

Consent to assist someone with access

An applicant can provide their consent for another person (e.g. support worker) to assist them during the access process. Options for assistance include:

- **Consent for the NDIA to share information** (e.g. the status of an access request) with a designated support worker. This will allow another person to contact the NDIA on an applicant's behalf, however the applicant will remain the primary point of contact for any correspondence from the NDIA e.g. the access decision. Complete our 'consent to assist in completing an access request' form to do this.
- **Consent for another person to be the primary point of contact** for all NDIA communications. This consent can be provided in Section 1, part C and D of the ARF. Although a support worker can be listed here it may be more appropriate to list a carer or other trusted representative to receive all NDIA communications.

Both the above consent options can be provided verbally e.g., during the VAR; however, we recommend providing written consent as a backup.

Disclaimer: The information contained in this publication is correct at the time of publishing (October 2021). The information provided in this document should not be relied on instead of other legal, medical, financial, or professional advice.