# Internal Review Access and Revocation Practice Guide

# 1. Purpose

This Practice Guide should be used with other relevant Standard Operating Procedures (SOP) such as the Complete Access or Revocation Internal Review s100 Decision SOP. It is intended that this Practice Guide supports decision making however, Internal Review Officers should always be considering relevant Legislation and Policy in the first instance when making decisions.

**Note**: All references to "applicant" in this document also refers to former participants (for revocations), authorised representatives, nominees, child representatives.

# 2. To be used by

- Access or Revocation Internal Review Officers (IROs).
- Access or Revocation Business Support Officers (BSOs).
- Access or Revocation Line Managers.

# 3. Scope

This Practice Guide will cover the following:

- General considerations when completing an Internal Review (IR).
- Requesting evidence and the options to guide IROs.
- Assessing substantially reduced functional capacity and gathering information.
- Templates and guidance to assist communication with Applicants.

# 4. Procedural Fairness or Natural Justice

When completing an Access or Revocation Internal Review, procedural fairness is applied throughout the review process so the correct decision is made according to the law.

The IRO must follow the principles during the internal review process:

**Bias Rule**: The decision maker must be impartial and approach the review with an open mind. If there is a conflict of interest, the IRO will advise your Line Manager for reassignment to another IRO.

**Evidence, facts and findings**: An IRO's decision is made on the available evidence.

IRO's may also request additional evidence.

# 5. Checking for integrity issues

When completing an Access or Revocation Internal Review, IRO's may encounter fraudulent documents or information. If and IRO believes fraudulent information has been provided, or there is a conflict of interest, the IRO must contact their Line Manager.

## 5.1 Examples of access integrity issues

### 5.1.1 NDIS Application consent

- Applicant does not have capacity to provide consent and they do not have a legally authorised representative.
- Applicant signed the ARF, however evidence indicates they do not have capacity to provide consent.

### 5.1.2 Treating professional information

- Unable to confirm all treating professional's qualifications and registration in AHPRA.
- Error in the treating professional's title.
- Contact information for the treating professional is the same as the applicant. For example, phone number, email address.
- Contact information for the treating professional is personal, rather than business.
- A treating professional should not be using personal email addresses (for example: Gmail, Hotmail, Outlook etc) due to privacy and security concerns.
- Address for treating professional is not a legitimate address. For example, address appears as another business when you search online through open-source information.
- Treating professional is not listed in AHPRA (evidence of disability indicates they have a profession that should be listed in AHPRA).
- Diagnosis provided by the treating professional does not align with their qualification.
- Impairment is self-reported. For example, applicant has approached a new GP and reported an impairment, however the GP has not confirmed the impairment with another treating professional, or completed their own assessment.
- Use of outdated terminology and/or assessment tools. For example, a recent report references the DSM-4.

### 5.1.3 Signs evidence of disability may not be genuine

- No difference in handwriting in the ARF in Section 2 (Parts A-F) between:

    - applicant section
    - treating professional section.
  - The treating professional completed Part E of the ARF to provide evidence of disability and Part G was not signed or dated.
  - Evidence of disability is all self-reported.
  - Documents are unprofessional. For example, spelling errors, inappropriate use of grammar, language, lack of appropriate detail or change in language style within the document.
- Name of another applicant appears in the document and/or misspelled names.

#### 5.1.4 Signs of altered documents

- Signs of text being removed, added, or changed within document. For example, white out used to remove important information.
- Inconsistent fonts, sizes, misalignment of text or paragraphs in documents.
- Poor character quality due to repeated scanning and photocopying. For example, document is hard to read.
- Partial documents from a treating professional.
- Documents can be edited.

#### 5.1.5 Signs of conflict of interest

- Provider that gave evidence of disability may benefit from the applicant becoming a participant.
- Interactions indicate excessive and repeated contact from provider, and provider may benefit from the applicant becoming a participant.
- Treating professional may be related to the applicant. For example, the treating professional has a similar name.
- Applicant has made more than 2 applications to access the NDIS and changed the primary disability each time.

# 6. Verifying age and residency

When completing an Access or Revocation Internal Review, at times, an applicant may not provide consent to verify age and residency through Centrelink. In this circumstance, an IRO must confirm age and residency through documentary evidence.

## 6.1 Verifying age

When checking an Applicant's age, their date of birth must match one of the following documents:

- Full birth certificate (an extract is not acceptable)
- My First Health Record ('Blue Book' in some states) signed by a doctor or midwife (only for a newborn under 3 months of age)
- Passport biodata page (the page that has their photograph on it) from a current passport of a passport that expired within the last 2 years (but was not cancelled)
- Proof of age card issued by state licensing authorities
- Driver's license
- Adoption papers
- ImmiCard.

## 6.2 Verifying an Applicant's home address

When checking an Applicant's home address, it must match one of the following documents:

- Utility bill (for either electricity, water, or gas), showing their home address (approximately within the last 3 months)
- Lease, rental agreement, or contract of house purchase (current year)
- Council rates notice (from the most recent financial year)
- Home insurance policy (current year).

If an applicant does not have a fixed address, discuss the applicant's circumstances with your Line Manager.

## 6.3 Verifying an Applicant's residency status

When checking an Applicant's residence status, it must match one of the following:

- Full Australian birth certificate (an extract is not acceptable) (with additional documents if the applicant was born on or after 20 August 1986)
- Australian passport biodata (the page that has their photograph on it) from a current passport or a passport that expired in the last two years (but was not cancelled)
- Australian citizenship or naturalisation certificate
- Overseas passport or travel document which includes a valid Australian Permanent Residency Visa or Protected Special Category Visa.

#### 6.3.1.1 **If the Applicant was born on or after 20 August 1986**

If the Applicant was born in Australia on or after 20 August 1986, check that the citizenship status matches one of the following documents:

- Australian passport issued on or after 1 January 2000 in the applicant's name, valid for at least 2 years; or
- Australian citizenship certificate; or
- full Australian birth certificate (an extract is not acceptable); and
- proof of one parent's Australian citizenship:
- full Australian birth certificate from one parent* (an extract is not acceptable), showing that the parent was born in Australia before 20 August 1986; or
- Australian passport from one parent* before the applicant's birth, valid for at least 2 years and issued on or after 20 August 1986; or
- Australian citizenship certificate from one parent*, showing that they were an Australian citizen before the applicant's birth.

Note: If the parent was born on or after 20 August 1986, the applicant will also need to provide proof that one of their grandparents was an Australian citizen before this date. If the applicant can only provide partial evidence (such as their own birth certificate without any other documents listed above), discuss their circumstances with your Line Manager to consider the most appropriate alternatives.

You can find a comprehensive list of examples and evidence requirements at the Australian Passport Office (external).

#### 6.3.1.2 If the Applicant holds a Protected Special Category Visa

New Zealand citizens who enter Australia on a New Zealand passport are granted a Special Category Visa (TY-444) (Temporary Visa).

A Special Category Visa holder is protected if they:

- were in Australia on 26 February 2001; or
- were in Australia for at least 12 months in the 2 years before 26 February 2001 and returned to Australia after that day.

There are two ways to obtain documentary evidence the applicant has a protected Special Category Visa. Both options need to show a visa class/subclass TY-444 and have a grant date of 26 February 2001 or before.

The two options are:

- VEVO Check online (the Applicant must have a valid passport or ImmiCard to obtain a VEVO check:
    - For an IRO to check: please contact your Line Manager for guidance

    - For an applicant to check: the applicant can provide a completed check to the IRO. The check can be completed on the Department of Home Affairs website.
- Receive an IMMI Grant Notification
    - Copy of the ImmiGrant notification that was issued at the time of granting the visa
    - If the person loses the original copy, they must contact the Department of Home Affairs for it to be reissued.

Note: If an Applicant does not have evidence to confirm that their Special Category Visa is protected, they will need to contact the Department of Home Affairs.

## 7. Weighing evidence of disability

When completing an Access or Revocation Internal Review, IRO's will see a range of different types of evidence from varying health professionals. When weighing the relevance and importance of the evidence of disability provided, the two main considerations an IRO needs to make are:

- Who is providing the evidence of disability
- How old is the evidence of disability (particularly relevant for evidence of functional capacity)

Further information about how an IRO weighs evidence is available in Our Guidelines - How do we weigh evidence of disability?

## 8. Identifying next steps through key indicators

Key indicators include evidence submitted with the Internal Review request or evidence from the original decision. It may include reports from allied health professionals or specialists that have assessed the Applicant. It may also include lived experience statements from the Applicant or other professionals who work closely with the Applicant and their families.

The National Disability Insurance Scheme (NDIS) internet page provides further guidance for primary disabilities and a list of treating health professionals that are appropriate to provide the standardised assessments. Further information is available at types of disability evidence.

Examples of key indicators are:

- Applicant relies on prescribed aides and devices for the majority of tasks most of the time (other than a common item).
- Applicant demonstrates a reliance or noted deterioration requiring the support/intervention of other people for the majority of tasks most of the time.

- Applicant is unable to perform tasks or actions needed to participate in an activity.

IROs identify whether these key indicators exist for an Applicant and if this will lead to a confirmed or set-aside of the original decision. This will determine the appropriate pathway for the Internal Review. During the course of the review, information or evidence provided may change the path of the review.

## 8.1 Option 1 – Original Decision is likely to be confirmed

Option 1 Internal Review Requests have no key indicators to meet Access requirements. The outcome is likely to be confirmed even if the Applicant provides further evidence.

### 8.1.1 Option 1 Scenario

The information and evidence provided for the internal review clearly indicates the original decision was correct.

The impairment is not a list A, B or D impairment.

Sections of the access criteria are not met (for example, a recent assessment will not meet the access criteria for permanence).

The evidence-based treatments and therapies have not been trialled or ruled out by treating practitioners.

Other than a new assessment impairment or rapid deterioration in functional capacity that the Applicant is unlikely to meet the access requirements.

The Applicant has indicated that they do not intend to provide further information or evidence in support of their review.

### 8.1.2 Management of Option 1 reviews

If an IRO is allocated an Internal Review and the acknowledgement letter has only recently been sent, the IRO will decide if enough time has been provided for the Applicant to provide further information before completing the internal review. Applicants have 14 days to supply additional evidence from the date the acknowledgement letter. For further guidance, refer to your Line Manager.

The IRO should not ask for any specific evidence from the Applicant or indicate that further evidence would alter the review outcome. Option 1 reviews are likely to be confirmed.

Follow the steps in Complete an Access or Revocation Internal Review Decision Standard Operating Procedure including a formal request for further information if the Applicant has indicated they would like to provide this.

## 8.2 Option 2 – Original decision is likely to be set aside with specific additional evidence

Option 2 Internal Review Requests have multiple key indicators to consider if the original decision may be set-aside.

### 8.2.1 Option 2 Scenario

The information provided has multiple key indicators the Applicant may meet Access requirements. For example List B impairment with secondary evidence that includes significant functional deficits, or a supporting evidence form from a General Practitioner which indicates a substantial reduction in functional capacity (SRFC) across a number of key life activities.

The original decision is likely to be set-aside with clarification or confirmation of these indicators. For example, the IRO is likely to set-aside the original decision after confirmation of a prescribed aid by an appropriate health professional.

### 8.2.2 Management of Option 2 Scenario

Where an IRO has identified an Option 2 scenario the IRO is to seek the required information. Aside from the phone calls, the IRO may try to seek consent to contact the Applicant's health professionals (where appropriate) to confirm information. Make sure other relevant steps in Complete an Access or Revocation Internal Review Decision Standard Operating Procedure are followed.

# 9. Gathering further evidence

An IRO may determine further evidence is needed in addition to what is on the System to reach the correct and preferable decision. Make sure other relevant steps in Complete an Access or Revocation Internal Review Decision Standard Operating Procedure are followed.

## 9.1 Functional impact of applicant's impairment

Further information can be collected by an IRO through contacting the Applicant to enquire about functional impact of their impairment. To assess the Applicants SRFC across the six relevant activities, contact will be made using the preferred communication method. The questions will be dependent on the Applicant's impairment type.

If the Internal Review is an Option 2 review and the Applicant has given the IRO consent to contact health professionals, the questions will depend on the health professional from whom you are requesting advice.

## 9.2 Formal Requests through a Further Information Request Letter

An IRO may request information or evidence from an Applicant to support consideration of Access criteria being met. The Applicant may also wish to provide more information.

A formal request will be issued via preferred method of correspondence by emailing or mailing a completed Internal Review Request for Information Letter or the Internal Review

Unable to Contact Letter (if contact has not been made) to the Applicant. Letter templates may be found on the Internal Review Access resources intranet page. The Internal Review Request for Information Letter and the Internal Review Unable to Contact Letter (when applicable) will detail the evidence required and will include the timeframe for return of evidence (usually up to 28 days allowed). For further information, refer to Section 10. Timeframes for return of requested evidence.

### 9.2.1 Examples templates for completing the Further Information Request Letter

The following are example templates to assist IROs to prepare the letter and complete the 'free text field' when further information is needed. These cover the most common requests an IRO will make according to sections of the National Disability Insurance Scheme Act 2013.

#### 9.2.1.1 Section 22 and 23 – requests regarding age and residency

Evidence is required which demonstrates <you/child's name> meet the <age/residency/age and residency> requirements. It is requested you provide formal documentation, which demonstrates <you/child's name> <date of birth/citizenship/visa status>.This can be provided by a <birth certificate/passport/visa documentation>. You can also provide consent for the NDIA to access your age and residency information from your Centrelink record.

#### 9.2.1.2 Section 24(1)(b) and Section 25(1)(a) – permanency of an impairment

Information from <you/applicant's name> treating professional about <your/their> <list all disabilities/impairments where information is needed>, including:

<any treatments that <you have/applicant's name has> previously undertaken to relieve or cure your/their impairment.>

<any treatments that <you are/applicant's name is> currently undertaking to relieve or cure <your/their> impairment.>

<the outcomes, or expected outcomes, of any current and/or previous treatments.>

<any available and appropriate treatment options that <you have/applicant's name has> not yet explored, and that are likely to relieve or cure <your/their> impairment. If there are known treatment options that <you/applicant's name> cannot undertake, <your/their> treating professional must provide information about why this is the case.>

Depending on the impairment, treatments may include medications, therapies, surgeries or rehabilitation.

Where possible, please get this information from the treating professional who is most relevant to <your/applicant's name> impairment. Examples of common treating professionals include:

- <Delete if N/A: Audiologist>

- <Delete if N/A: Neurologist>
- <Delete if N/A: Orthopaedic Surgeon>
- <Delete if N/A: Ophthalmologist>
- <Delete if N/A: Paediatrician>
- <Delete if N/A: Pain Specialist>
- <Delete if N/A: Psychiatrist>
- <Delete if N/A: Psychologist>
- <Delete if N/A: Rheumatologist>
- <Delete if N/A: Rehabilitation Specialist>
- <If applicable: Enter relevant professional>
- <If applicable: Enter relevant professional>
- <If applicable: Enter relevant professional>
- General Practitioner (GP)

<Delete if N/A: A copy of any existing reports, assessments or documents that <Professional's name> referenced in their <type of evidence document> from <date of evidence/document.>

#### 9.2.1.3 Section 24(1)(c) – functional impact of a permanent impairment

<Information about the specific everyday tasks that <you/applicant's name> cannot effectively complete without support, relating to <you/their> <list all disabilities/impairments where functional information is needed>. This might include details about what a typical day or week looks like for <you/applicant's name>.>

<Information about the disability-specific supports that <you/applicant's name> usually <need/needs> to <move around/communicate/socialise/learn/look after <yourself/themselves> / organise <your/their> life>.>

Disability-specific supports include:

- a high level of support from other people, such as physical assistance, guidance, supervision or prompting
- assistive technology, equipment or home modifications that are prescribed by your doctor, allied health professional or other medical professional.

<your/applicant's name> treating professional should provide information that describes the type of support <you/they> need, how often <you/they> need it and the duration.> <Include all relevant domains>

- <Mobility (or moving around) – how easily you move around your home and community, and how you get in and out of bed or a chair. We consider how you get out and about, and use your arms or legs.>
- <Communicating – how you speak, write, or use sign language and gestures, to express yourself compared to other people your age. We also look at how well you understand people, and how others understand you.>
- <Socialising – how you make and keep friends, or interact with the community, or how a young child plays with other children. We also look at your behaviour, and how you cope with feelings and emotions in social situations.>
- <Learning – how you learn, understand and remember new things, and practise and use new skills.>
- <Self-care – personal care, hygiene, grooming, eating and drinking, and health. We consider how you get dressed, shower or bathe, eat or go to the toilet.>
- <Self-management (if older than 6) – how you organise your life. We consider how you plan, make decisions, and look after yourself. This might include day-to-day tasks at home, how you solve problems, or manage your money. We consider your mental or cognitive ability to manage your life, not your physical ability to do these tasks.>

Where possible, please get this information from the treating professional who is most relevant to <your/applicant's name> impairment. Examples of common treating professionals include:

- <Delete if N/A: Audiologist>
- <Delete if N/A: Neurologist>
- <Delete if N/A: Orthopaedic Surgeon>
- <Delete if N/A: Ophthalmologist>
- <Delete if N/A: Paediatrician>
- <Delete if N/A: Pain Specialist>
- <Delete if N/A: Psychiatrist>
- <Delete if N/A: Psychologist>
- <Delete if N/A: Rheumatologist>
- <Delete if N/A: Rehabilitation Specialist>
- <If applicable: Enter relevant professional>
- <If applicable: Enter relevant professional>

- <If applicable: Enter relevant professional>
- General Practitioner (GP)

<Delete if N/A: A copy of any existing reports, assessments or documents that <Professional's name> referenced in their <type of evidence document> from <date of evidence/document.>

9.2.1.4 Section 25(1)(b) and/or Section 25(3) – early intervention reducing future need for support and/or most appropriate service system

Information from <your/applicant's name> treating professional about:

- <any capacity building supports recommended for <you/applicant's name>, and their expected outcomes.>
- <any capacity building supports that have already been implemented, and their outcomes.>
- <a copy of <your/applicant's name> most recent audiogram and information about <your/their> need for personal amplification.>
- <a copy of any existing reports, assessments or documents that <name of treating professional> referenced in their <type of evidence/document> from <date of evidence document.>

Where possible, please get this information from the treating professional who is most relevant to <your/applicant's name> impairment. Examples of common treating professionals include:

- <Delete if N/A: Audiologist>
- <Delete if N/A: Neurologist>
- <Delete if N/A: Orthopaedic Surgeon>
- <Delete if N/A: Ophthalmologist>
- <Delete if N/A: Paediatrician>
- <Delete if N/A: Pain Specialist>
- <Delete if N/A: Psychiatrist>
- <Delete if N/A: Psychologist>
- <Delete if N/A: Rheumatologist>
- <Delete if N/A: Rehabilitation Specialist>
- <If applicable: Enter relevant professional>
- <If applicable: Enter relevant professional>

- <If applicable: Enter relevant professional>
- General Practitioner (GP)

<Delete if N/A: A copy of any existing reports, assessments or documents that <Professional's name> referenced in their <type of evidence document> from <date of evidence/document.>

9.2.1.5 Section 25(1)(a) – Developmental delay

Information from <child's name> treating professional about:

- <child's name> functional capacity in self-care, receptive and expressive language, cognitive development and motor development, compared to children of the same age.>
- <each of the early intervention supports recommended for <child's name>, including their expected outcomes.>
- <the expected frequency and duration of the recommended supports.>
- <Very young children (delete this heading)> <whether there is a risk of future disability diagnosis or developmental delay where impairment and/or functional capacity cannot be easily measured due to <child's name> age.>

Where possible, please get this information from the treating professional who is most relevant to <child's name> developmental delay. Examples of common treating health professionals include:

- <Delete if N/A: Occupational Therapist>
- <Delete if N/A: Paediatrician>
- <Delete if N/A: Psychologist>
- <Delete if N/A: Physiotherapist>
- <Delete if N/A: Speech Pathologist (Therapist)>
- <If applicable: Enter relevant professional>
- <If applicable: Enter relevant professional>
- <If applicable: Enter relevant professional>
- General Practitioner (GP)

<Delete if N/A: A copy of any existing reports, assessments or documents that <Professional's name> referenced in their <type of evidence document> from <date of evidence/document.>

# 10. Timeframes for return of requested evidence

The standard timeframe is 28 days for the return of further evidence or information. This is not a legislative timeframe but is considered a reasonable timeframe for procedural fairness in administrative review.

An IR decision must not proceed unless either the further information timeframe has passed, the person has provided further information, or the unable to contact timeframe has passed.

If information is provided prior to the timeframe expiring, IROs would need to make contact to confirm all documents have been received, and that there is no further documents to be provided. If there are no further documents to provide, the IRO can then progress with the review. Otherwise, if there are documents still to be received, the IRO would need to wait the full timeframe.

This timeframe may be adjusted if considered reasonable – for example if the person advises the evidence will be emailed within a few business days, it may be reasonable to agree on an earlier timeframe for provision of evidence and follow up (for example, 7 calendar days).

If the Applicant will need to see their health professional to obtain copies of documents and send them via mail, 28 calendar days for return of this evidence would be a reasonable timeframe.

Note: Section 26 of the NDIS Act outlines the requests that the CEO may make after an applicant has made an access request, which includes requesting information or reports with a 28 day timeframe. Section 26 of the NDIS Act does not apply to Access and Revocation Internal Reviews, and is only relevant to initial access decisions. Similarly, our Guidelines, How do we decide if you're eligible?, stipulates a 90 day timeframe to supply evidence if requested, which is also only relevant to initial access decisions not Internal Reviews.

## 10.1 Requests for extensions for provision of evidence for an Internal Review

When an Applicant asks for extra time to provide further evidence there must be a clear reason for the IRO to agree. Some examples are in section 10.1.1.

A fair extension would be an additional 7-14 days (a total of 36-43 days since the evidence was requested). This is not a legislative requirement but allows a reasonable timeframe for evidence to be returned.

If an extended timeframe for further information will lead the review to becoming older than 60 days, consult with your Line Manager for endorsement of the timeframe extension.

If a Line Manager approves an extension, it must be recorded as an interaction on the System. The IR Access database is to be updated with the date of extension and the reason for the extension within the Review/Call Log Tab.

### 10.1.1 Examples of exceptional circumstances for supported extensions for FIR

There are a range of exceptional circumstances listed below which may result in an

extension of time to provide evidence. Consideration is given for other matters that may require an extension.

- Specialist appointment or Allied Health Professional appointment has been booked but has not yet occurred;
- Local or State Emergencies or severe weather events impacting on gathering of evidence;
- Rural or Remote geographical impacts (visiting specialists);
- Changes to caring arrangements, including informal supports, due to death, serious illness or injury of informal supports, or significant and unexpected deterioration of disability-related functional capacity;
- Risk to self, others, community or agency reputation;
- A person is living in an emergency declared region which has been affected by a recent emergency;
- A person requires a specialist appointment and there is a long wait for appointments; a person is hospitalised and has no advocate, which can assist with gathering additional evidence;
- Unstable or fragile arrangements can also be considered (for example risk of relinquishment of a child);
- Applicants who do not have any disability specific supports in place and are re-entering the community after a long term residential stay (for example prison release, mental health treatment release, newly acquired significant disability, spinal cord injury);
- Recent or upcoming hospital admission or discharge;
- Impacts of COVID related self-isolation or other health related impacts preventing the gathering and/or provision of additional information.

## 10.2 Substantially Reduced Functional Capacity (SRFC)

Access or Revocation Internal Review S100 decisions are made based on the NDIS Act, Becoming a Participant Rules and relevant Guidelines.

This involves considerations against the age access criteria (s 22), residence (s 23), disability (s 24), and early intervention criteria (s 25).

As part of the considerations for disability requirements (s 24), an IRO is required to assess whether an Applicant has SRFC in one or more relevant activities in mobility, self-care, learning, self-management, communication or social interaction (section 24(1)(c) of the NDIS Act 2013). These activities are defined in Our Guidelines - Applying to the NDIS.

An IRO will assess SRFC for an Applicant by reviewing the available evidence of the Applicants current functional capacity or impairments against the relevant activities.

Our Guidelines - Applying to the NDIS describes when an impairment is likely to result in a SRFC to perform one or more activities.

Our Guidelines - Applying to the NDIS is used together with this document. Discuss with a line manager or request advice from the Technical Advisory Branch (TAB) if further guidance is required. Instructions on how to request advice with TAB are on the Requesting Advice intranet page.

Substantially Reduced Functional Activity examples across the six key life activities is found in Appendix A.

# 11. Completing the Access or Revocation Decision Letters and Basis of Decision

A letter and basis of decision (in the same document) will need to be completed to inform the Applicant of the outcome. Letter and basis of decision templates are available on the Internal Review Access resources intranet page.

For set-aside decisions, the letter Internal Review of Access or Access Revocation Decision Successful Letter will need to be completed.

For confirmed decisions, the letter Internal Review of Access or Access Revocation Decision Unsuccessful Letter will need to be completed.

The criteria for meeting Access for the Internal Review must be identified in the letter for set aside decisions. Free text guidance for criteria's are in the Internal Review of an Access or Revocation Request Interaction Templates.

The reasons for declining Access for the Internal Review is to be clearly explained with reference to which criteria is not met.

The following sections are example wording to complete the Access or Revocation successful and unsuccessful decision letter and/or the basis of decision at the end of the letter for Access criteria.

Depending on the circumstances and evidence the wording can be modified in the below examples.

Note: Further assessments of access eligibility are not required if eligibility for age and residence criteria are not met. The IRO can delete all reference to other criteria on the Access or Revocation decision letters.

## 11.2 Set Aside Decisions

### 11.2.1 Listing impairments/conditions within Successful Letters

When completing the Internal Review of Access or Revocation Decision Successful Letter, ensure that the impairments/conditions that meet the access requirements of either Disability, Early Intervention, or Developmental Delay are included.

For example: An Applicant has met the access criteria for both a neurological and psychosocial impairment, being Multiple Sclerosis and Schizophrenia. The letter would state "You have met the Disability criteria for Multiple Sclerosis and Schizophrenia."

If, using the same example, the Applicant met the access criteria for their neurological impairment of Multiple Sclerosis, but did not meet the criteria for their psychosocial impairment of Schizophrenia, the letter would state "You have met the Disability criteria for your Multiple Sclerosis".

## 11.3 Age Not Met (s22)

The criteria for access to the NDIS is set out in section 22 of the National Disability Insurance Scheme Act 2013, which states a person must be aged under 65 when a valid access request was made. The NDIA is unable to waive this legislative requirement.

As <you/applicant's name> were not younger than 65 on the day <you/applicant's name> made your NDIS application, <you/applicant's name> do not meet the age requirements.

Further assessment of <your/applicant's name> eligibility in relation to the Residency, Disability, and Early intervention requirements (set out in sections 23, 24 and 25 of the National Disability Insurance Scheme Act 2013) will not be considered as part of this internal review.

## 11.4 Residence Not Met

The criteria to access the NDIS is set out in section 23 of the National Disability Insurance Scheme Act 2013, which states a person must meet the residence requirements to meet the access criteria. The NDIA is unable to waive this legislative requirement.

As <you/applicant's name> <reason for not meeting: for example <are not the holder of a permanent visa/are not Australian citizen>, you do not meet the residency requirements.

As <you/applicant's name>do not meet the residence requirements, further assessment of your eligibility in relation to the Disability and Early intervention requirements (set out in sections 24 and 25 of the National Disability Insurance Scheme Act 2013) will not be considered as part of this internal review.

## 11.5 Disability Not Met

### 11.5.1 Does not meet Section 24(1)(a): Impairment attributable to disability

For the purposes of becoming a participant of the NDIS, (as outlined in the Our Guidelines - Applying to the NDIS) when we consider your disability we think about whether any reduction

or loss in your ability to do things, across all life domains, is because of an impairment. The term ‘impairment’ is a loss or significant change in at least one of:

- your body’s functions
- your body structure
- how you think and learn

11.5.1.1 Applicant does not have evidence of impairment and disability

Evidence provided does not demonstrate <your/applicant’s name> <condition/name diagnoses> <result/s> in an impairment or disability attributable to an impairment. As such, <they/name of condition> will not be assessed further in this review.

11.5.1.2 Applicant has no evidence of disability

Evidence provided does not indicate <your/applicant’s name> <condition/s> of <name of diagnoses> results in a reduction or loss in <your/applicant’s name> ability to do things, and as such, I have concluded <it/they> <has/have> not resulted in disability consistent with NDIS requirements. As such, <they/name of condition> will not be assessed further in this review.

11.5.1.3 Applicant has no evidence of impairment

As <diagnosis/diagnoses> <is/are> not a loss or significant change to <your/applicant’s name> body’s functions, structure, or how <you/applicant’s name> think and learn, I have concluded <this/these conditions> cannot be considered <an impairment/s> consistent with NDIS requirements. As such, <they/name of condition> will not be assessed further in this review.

**11.5.2 Does not meet Section 24(1)(b): Permanency**

Importantly, even when a condition or diagnosis is permanent, the NDIA must assess the permanency of the associated and resulting impairment(s) (for example, reduced capacity for mobility, socialising and so on). In line with Our Guidelines - Applying to the NDIS, a person may not be eligible if their impairment is temporary, still being treated, or if there are remaining treatment options. Generally, the NDIA will consider a person’s impairment is likely to be permanent after all available and appropriate treatment options have been pursued.

To effectively assess the functional impact of an applicant’s impairment, the NDIA must have sufficient evidence that demonstrates that the impairment has been optimally treated and stabilised. Evidence must also outline that an applicant’s baseline level of functioning has been established before an accurate determination of their functional capacity can be made regarding their eligibility for the NDIS.

In making this determination, I have consulted the following legislation and guidelines:

- Section 5.4 of the National Disability Insurance Scheme (Becoming a Participant) Rules 2016, which states, an impairment is, or is likely to be permanent only if there

are no known, available and appropriate evidence-based clinical, medical or other treatments would be likely to remedy the impairment.

- Section 5.6 of the National Disability Insurance Scheme (Becoming a Participant) Rules 2016, which states, an impairment may require medical treatment and review before a determination can be made about whether the impairment is permanent or likely to be permanent. The impairment is, or is likely to be, permanent only if the impairment does not require further medical treatment or review in order for its permanency or likely permanency to be demonstrated (even though the impairment may continue to be treated and reviewed after this has been demonstrated).
- Our Guidelines - Applying to the NDIS states if a person is still undergoing or have recently had treatment. We'll need to wait until the outcome of the treatment is known before we can determine your impairment is likely to be permanent.

11.5.2.1 Applicant is undergoing treatment or has treatment available

It is acknowledged <your/applicant's name> <have/has> experienced long-standing symptoms and difficulties as a result of <your/applicant's name> diagnosed conditions. However, information provided by <name> indicates <your/applicant's name> are currently <undergoing <type of treatment. For example "Group based Dialectical Behaviour Therapy (DBT)"> <or/and> <recommended by <name> to engage with <type of treatment>>.

As the evidence indicates that <you/applicant's name> <have/has> not completed all available and recommended treatments, the likely permanency of <your/applicant's name> impairment cannot be determined at this time. Without specialist evidence confirming that all available treatment options have been explored, completed, and that <your/applicant's name> <impairment/s have/has> been optimally treated and stabilised, your <impairment/s> cannot meet this criterion.

11.5.2.2 Applicant has received some treatment

The evidence states <your/applicant's name> <have/has> received some appropriate and recommended treatments for <your/applicant's name impairment/s>. However, there is not enough information to confirm that there are no further known and available appropriate evidence-based treatments that are likely to remedy <your/applicant's name impairment/s>.

Without specialist evidence confirming that all available treatment options have been explored, completed, and that <your/applicant's name> impairment/s have/has> been optimally treated and stabilised, <your/applicant's name impairment/s> cannot meet this criterion.

11.5.2.3 Applicant has not provided treatment history

The NDIA does not determine whether there are any interventions, treatments or therapies, which would remedy an impairment. The evidence provided does not address any previously completed treatment, current treatment, or future treatment, which may have been

recommended to <you/applicant's name>. Therefore, it cannot be concluded all available and appropriate treatments options which may remedy <your/applicant's name disability type/s/condition> have been pursued.

11.5.2.4 Treatment history is not thorough

The evidence received does not include a detailed treatment history for <your/applicant's name impairment/s>. Detailed evidence of <your/applicant's name> treatment history should include a timeline of treatments undertaken, types and frequency of treatments, the duration and outcome of treatments, including a report from <your/applicant's name> <Treating Practitioner/Specialist> about the outcomes.

The evidence does not conclude that all recommended treatment options have been explored and completed. Therefore, based on the provided evidence, the permanency of <your/applicant's name impairment/s> cannot be determined at this time.

11.5.2.5 Future applications would benefit from further information

Future applications would benefit from a thorough treatment history for <your/applicant's name impairment/s> indicating the outcomes of all medical treatment, <surgical intervention (if applicable)>, specialist reviews, and specialist prognosis. The evidence would need to show that all readily available and evidence based treatments that would be likely to remedy <your/applicant's name impairment/s> have been completed, become unavailable, or no longer deemed medically viable by the relevant treating professionals/specialists.

**11.5.3 Does not meet Section 24(1)(c): Substantially reduced functional capacity**

The NDIA acknowledges that <you/applicant's name live/s> with limitations that affect <your/applicant's name> functional capacity, that <you/applicant's name have/has> had to adjust the way <you/applicant's name> do things and occasionally rely on others for assistance. However, to meet this criterion, the evidence must demonstrate that an applicant usually needs disability-specific support to participate or complete activities in one or more of the six key activities assessed (communication, social interaction, learning, mobility, self-care, and self-management).

As described in Our Guidelines - Applying to the NDIS, disability-specific supports that are deemed to substantially reduce an applicant's functional capacity in the key activities include:

- a high level of support from other people, such as physical assistance, guidance, supervision or prompting
- assistive technology, equipment or home modifications that are prescribed by your doctor, allied health professional or other medical professional.

Information provided indicates that <your/applicant's name impairment/s have/has> resulted in difficulties with completing certain tasks. The NDIA acknowledges that <you/applicant's name> experience challenges which prevent <you/applicant's name> from fully participating in some tasks and the seriousness and significance of <your/applicant's name> impairment is

not disputed. However, I have been unable to conclude from the existing evidence that <you/applicant's name> usually require a high level of support from other people, assistive technology, or equipment and home modifications to complete the activities assessed and to ensure your safety and independence in the community.

In making, this determination I have referred to Section 5.8 of the National Disability Insurance Scheme (Becoming a Participant) Rules 2016, which states an impairment results in a substantial reduction in functional capacity if:

- The person is unable to participate effectively or completely in the activity, or to perform tasks or actions required to undertake or participate effectively or completely in the activity, without assistive technology, equipment (other than commonly used items such as glasses) or home modifications; or
- The person usually requires assistance from other people to participate in the activity or to perform tasks or actions required to undertake or participate in the activity; or
- The person is unable to participate in the activity or to perform tasks or actions required to undertake or participate in the activity, even with assistive technology, equipment, home modifications or assistance from another person.

11.5.3.1 Not met due to impairments not being considered permanent

As explained in Our Guidelines - Applying to the NDIS, the NDIA only considers an applicant's permanent impairments when assessing their functional capacity or ability to undertake activities

As noted in Section 24(1)(b) <your/applicant's name impairment/s> cannot be considered permanent; therefore, this criterion has not been met.

11.5.3.2 Not met as reduced capacity is only limited to activities required to be completed in a slower or modified manner

I understand <your/applicant's name impairment/s have/has> resulted in difficulties with a number of tasks, and <you/applicant's name> may need to complete these tasks in a slower or different manner. For example, <refer to applicant's individual functional evidence for relevant tasks. For example. "When mobilising in the community, you need to take rest breaks before you are able to mobilise further. When getting dressed you do so in a seated manner".> While it is noted that <you/applicant's name> do have a reduced functional capacity, it cannot be said that <you/applicant's name have/has> a substantially reduced functional capacity as <you/applicant's name do/does> not require a high level of support from other people, assistive technology, or home modifications.

11.5.3.3 Not met as the assistive items stated to be required are commonly used items

I understand <you/applicant's name require/s and benefit/s> from equipment such as <insert item for example <a walking stick, shower chair and bathroom grab rails>. Reliance on such

<an item/items> is not considered substantially reduced functional capacity as the <item/items> required <is/are> considered to be a 'commonly used item'/'commonly used items' rather than specialist equipment or technology that is specifically designed to increase the functional capacity and participation of people with disability.

11.5.3.4 Not met as reduced capacity only occurs during acute episodes

Evidence provided indicates <your/applicant's name> impairment is fluctuating and <your/applicant's name> experience greater difficulty with daily tasks during certain periods. For example <insert circumstances related to acute episodes for example when unwell you require personal assistance with showering>.

The NDIA considers an applicant's ability over time, taking into account their ups and downs. When an impairment is fluctuating or episodic, a person's ability to undertake activities is considered between periods of exacerbation, on an average day. From the evidence provided, I cannot determine that, on an average day, you require a high level of support from other people, assistive technology, or home modifications.

11.5.3.5 Not met as no evidence provided for reduced functional capacity

I understand <your/applicant's name impairment/s have/has> resulted in difficulties with a number of tasks, however, based on the information provided, there is no evidence to indicate <you/applicant's name has/have> reduced functional capacity or ability to participate in activities in one of the following: communication, social interaction, learning, mobility, self-care or self-management.

**11.5.4 Does not meet Section 24(1)(d): Social and economic participation**

11.5.4.1 Does not reduce capacity for social and economic participation

The evidence provided does not currently demonstrate that <your/applicant's name> impairment has impacted <your/applicant's name> capacity for social and economic participation.

11.5.4.2 Not met due to impairments not being considered permanent

As explained in Our Guidelines - Applying to the NDIS, the NDIA only considers an applicant's permanent impairments when assessing their ability to participate socially and economically.

As noted in Section 24(1)(b) <your/applicant's name> impairment/s are not considered to be considered permanent; therefore, this criterion has not been met.

**11.5.5 Does not meet Section 24(1)(e): Lifetime support**

In order to meet this criterion, an applicant must be likely to need support under the NDIS for their whole life. When we decide if an applicant likely needs support under the NDIS for their whole life, we consider:

- A person's life circumstances

- the nature of a person's long-term support needs
- whether a person's needs could be best met by the NDIS, or by other government and community services

In accordance with Schedule 1 of the National Disability Insurance Scheme (Supports for Participants) Rules 2013, these considerations must be taken into account when deciding whether a support is more appropriately funded by the NDIS or another service system. For example, while the NDIS is responsible for supports related to a person's ongoing functional impairment, the NDIS is not responsible for the diagnosis and clinical treatment of health conditions, including ongoing or chronic health conditions.

It is clear the challenges <you/applicant's name> face are unique and significant and <you/applicant's name> would benefit from support. However, without meeting the criteria outlined within Section 24(1)(b)(c), it cannot be said that <you/applicant's name> require the support of the NDIS for <your/applicant's name> lifetime, and thus <your/applicant's name> support needs are not best met through the NDIS.

11.5.5.1 For child applicants younger than 7 years of age at the time of the internal review outcome

The early childhood approach is for children younger than 7 years. Children, younger than 6 who do not fully meet the definition of developmental delay and have developmental concerns will also be supported through the early childhood approach. The early childhood approach was developed based on evidence based research with the help of leading experts in early childhood intervention. In many areas around Australia, Early Childhood (EC) Partners are available to help provide support for <your child's/child's name> need.

EC Partners are local organisations that are funded to deliver the early childhood approach. The EC Partner for your region is <EC Partner Details> who are located at <address>. They can be contracted by phone on <phone number> or via email <email address>.

11.5.5.2 For applicants 7 and over at the time of the internal review outcome

Local Area Coordinators are available to assist people that are not eligible for the NDIS to link with mainstream services. The Local Area Coordinator for <your/applicant's name> region is < Local Area Coordinator Details> who are located at <address>. They can be contracted by phone on <phone number> or via email <email address>.

11.5.5.3 If applicable for applicants who may be eligible for aged care assistance

Include wording in 9.3.4.2 along with wording below. If IRO is unsure of whether to include this information relating to the applicant's situation, please seek advice from your Line Manager.

<You/Applicant's Name> may also be eligible for supports through the aged care system via an early aged care assessment. <You/Applicant's Name> can speak to your Local Area

Coordinator or General Practitioner about this or call my aged care on 1800 200 422 for further information.

## 11.6 Early Intervention Not Met

### 11.6.1 Does not meet Section 25(1)(a): Permanent Disability or Developmental Disability

11.6.1.1 No identified impairment/diagnosis is not an impairment

Our Guidelines - Applying to the NDIS, explains that to meet this criterion, an applicant must have an impairment that is likely to be permanent. When deciding if a person has an impairment that is likely to be permanent, the NDIA considers the same things as with the disability requirements.

As outlined in criterion (a) of the Disability requirements, I am unable to conclude from the evidence provided <your/applicant's name> condition of <diagnosis> is a loss of, or damage to a physical, sensory or mental function. As such, it cannot be determined that <you/applicant's name> meet this criterion.

11.6.1.2 No permanent impairment

Our Guidelines - Applying to the NDIS, explains that to meet this criterion, an applicant must have an impairment that is likely to be permanent. When deciding if a person has an impairment that is likely to be permanent, the NDIA considers the same things as in the disability requirements.

As outlined in criterion (b) of the Disability requirements, I am unable to conclude from the evidence provided <your/applicant's name impairment/s is/are permanent. As such, it cannot be determined that <you/applicant's name> meet this criterion.

11.6.1.3 No developmental delay

When we decide if a child has developmental delay, we use the definition in Section 9 of the NDIS Act 2013.

We need to know that the child is under the age of 6 and that the delay:

- is due to mental or physical impairments
- substantially reduces the child's functional capacity compared with other children the same age
- means the child needs specialist services from more than one professional working as a team to support the child and for longer than 12 months.

<option: does not meet age – As <child's name> was already 6 years of age at the time of the original access request, it cannot be said that <child's name> has a developmental delay, and therefore cannot meet this criterion>

<option: does not indicate a substantial delay: As the evidence provided does not outline <child's name> has a substantial reduction in functioning in either self-care, receptive and expressive language, cognitive development, or motor development, it cannot be said that <child's name> meets the definition of a developmental delay under Section 9 of the NDIS Act 2013. As such, this criterion cannot be met.

<option: does not require multidisciplinary support: As the evidence does not indicate that <child's name> needs specialist services from more than one professional working as a team to provide support for longer than 12 months, it cannot be said that <child's name> has a developmental delay as per Section 9 of the NDIS Act 2013. and therefore cannot meet this criterion>.

**11.6.2 Does not meet Section 25(1)(b): reduces future support needs**

11.6.2.1 Longstanding impairment

To meet this criterion, Our Guidelines - Applying to the NDIS explain that early intervention (early access to supports) must be likely to reduce a person's future disability support needs.

Due to the long-standing nature of <your/applicant's name impairment/s>, I am not satisfied the supports required are 'early intervention' in nature. From the evidence provided, <early intervention supports are not likely to reduce your/applicant's name future needs for support in relation to disability/there is no information available to determine that early intervention supports likely to reduce your/applicant's name future support needs in relation to disability>.

11.6.2.2 No evidence of EI supports being required

To meet this criterion, Our Guidelines - Applying to the NDIS explain that early intervention (early access to supports) must be likely to reduce a person's future disability support needs. From the evidence received, there is no information to determine that early intervention supports are likely to reduce <your/applicant's name> future support needs in relation to disability.

**11.6.3 Does not meet Section 25(1)(c): Improves functional impact in key life area**

1. Improvement (I) – lessen the impairment's impact on the functional capacity for communication, social interaction, learning, mobility, self-care or self-management; or
2. Improvement (ii) – prevent the deterioration of functional capacity; or
3. Improvement (iii) – improve functional capacity; or
4. Improvement (iv) – strengthen informal supports, including building the carer's capacity.

Evidence provided does not indicate early intervention supports are likely to benefit you by achieving one or more of the outcomes listed above. There is no indication in the evidence provided as to what benefits may or may not be experienced from receiving support.

**11.6.4 Does not met Section 25(3): Most appropriate service system**

To meet this criterion, the support a person requires must be most appropriately funded or provided by the NDIS.

A person won't be eligible if we decide the support required is more appropriately funded or provided:

- by other general systems of service delivery or support services, such as a workers compensation scheme
- under a universal service obligation that other government services must provide to all Australians, such as schools and public hospitals
- as a reasonable adjustment under discrimination law, such as making places or venues accessible for you.

The evidence provided does not indicate that early intervention supports are most appropriately funded by the NDIS. Early intervention for <your/applicant's name impairment's is/are> most appropriately provided through the Health System or other government services. Clinical treatment is the responsibility of the Health System and not the NDIS.

This determination is in line with Our Guidelines - Applying to the NDIS. Further information on when early intervention supports are more appropriately funded by the NDIS or by other services can be found here:

- Our mainstream and community supports guideline
- Schedule 1 of the NDIS (Supports for Participant) Rules

11.6.4.1 Mainstream Early Intervention

The information does not indicate that early intervention supports are most appropriately funded by the NDIS. Early intervention for <your/applicant's name> psychosocial impairment is most appropriately provided through the Health System. Treatment of mental illness including acute inpatient, ambulatory, rehabilitation/recovery, early intervention and clinical support for child and adolescent developmental needs is the responsibility of the Health System and not the NDIS.

11.6.4.2 Developmental Delay – The NDIS is not the most appropriate system

To meet this criterion, the support a child requires must be most appropriately funded or provided by the NDIS.

A child won't be eligible if we decide the support required is more appropriately funded or provided:

- by other general systems of service delivery or support services, such as a workers compensation scheme
- under a universal service obligation that other government services must provide to all Australians, such as schools and public hospitals

- as a reasonable adjustment under discrimination law, such as making places or venues accessible for you.

For example, children usually won't be eligible if they only need the following supports. These are more appropriately provided by other government and community services:

- medical services, and treatments for health conditions
- inclusion supports to help young children join early childhood learning and care settings
- school readiness programs to help children prepare for school
- newborn follow-up, such as child and maternal health services.

It has been considered <child's name> would benefit from intervention during this period in their life. However, as outlined above in Section 25(1)(a), as <child's name> does not meet the definition of developmental delay under Section 9 of the NDIS Act 2013 and Our Guidelines - Applying to the NDIS, it cannot be said that <child's name> has a developmental delay, and therefore the NDIS is not the most appropriate agency to fund supports.

This determination is in line with Our Guidelines - Applying to the NDIS. Further information on when early intervention supports are more appropriately funded by the NDIS or by other services can be found here:

- Our mainstream and community supports guideline
- Schedule 1 of the NDIS (Supports for Participant) Rules

# 12. Appendices

## 12.1 Appendix A – Examples of SRFC under the Six Key Life Activities

The following reference to Rules refer to the National Disability Insurance Scheme (Becoming a Participant) Rules 2016.

### 12.1.1 Mobility

12.1.1.1 Rule 5.8(a) reliance on prescribed aides and devices

SRFC may look like but is not limited to:

- The use of a prescribed wheelchair or mobility scooter (for either short or longer distances);
- Prescription of an AFO (Ankle Foot Orthosis) or KFO (Knee Foot Orthosis);
- Prescribed build up shoes related to a disability such as Post-Polio Syndrome;
- Prescription or use of callipers;

- Reliance upon Prosthetics required for amputated lower limbs/congenital missing limbs (missing toes, forefoot without the prescription of aides may not meet SRFC);
- Hoists or slings.

Note: An IRO would assess prescribed aids based on the recommendations and prescriptions of health professionals. If a person chooses not to wear a prescribed aide as they feel it is uncomfortable or does not fit, this should not disqualify them.

12.1.1.2 Rule 5.8(b) reliance on the support/intervention of others

SRFC may look like a combination of these indicators but is not limited to

- Assistance needed to stand and walk around the community or propel a wheelchair;
- Frequent falls and unable to get up off the floor without assistance;
- Using a number of common items such as 4 wheel walkers, frame and walking sticks, single point sticks, quad cane Canadian crutches, forearm crutches, belt strap as well as standby support of another person.

12.1.1.3 Rule 5.8(c) unable to participate in the activity

SRFC may look like but is not limited to:

- Hoist or slings transfers to a motorised wheelchair with reliance on another person for 24/7 mobility support.

12.1.1.4 Psychosocial Disability

It would be unusual to see a SRFC in mobility attributable to a psychosocial condition without any comorbidities present. An example of reduced capacity for mobility resulting from a psychosocial impairment alone would be a conversion disorder (also known as functional neurological disorder) where psychosocial impairment shows as physical symptoms. Further information can be found in the Access Practice Guide - Psychosocial Disability.

12.1.1.5 Examples of what evidence may NOT meet the requirements of SRFC for Mobility include:

- Build up shoes used for leg length discrepancies or stand-alone foot or back conditions;
- Orthopaedic inserts;
- Charcot Restraint Orthotic Walker (CROW) boots- even when these are formally prescribed they are viewed as temporary aides;
- Four wheel walkers or frame and walking sticks, single point sticks, quad cane, Canadian crutches, forearm crutches used independently for short or long distances. These items can be purchased from Chemists and Mobility Shops and do not require a formal prescription from a suitably qualified health professional;

- Mobility scooter or wheelchair self-purchased or borrowed that has not been formally prescribed;
- Not being able to complete isolated tasks such as sweep and mop, scrub shower recesses, mow lawns, complete household cleaning tasks, carry groceries, and lift small items such as a cooking pot. With regard to household tasks the functional evidence obtained should be weighed up to see if the applicant experiences substantially reduced functional capacity in the broader sense of the functional domain rather than in isolated tasks;
- Not being able to catch public transport.

### 12.1.2 Self-Care

12.1.2.1 Rule 5.8(a) reliance on prescribed aides and devices

SRFC may look like but is not limited to:

- Slings Hoist transfers for bathroom access;
- Use of prosthetics for self-care tasks. The requirement of prosthetics for upper limb amputations/congenital missing limbs would result in SRFC in Self-care. An additional discussion may be needed with your Line Manager or TAB with regard to missing fingers;
- Percutaneous Endoscopic Gastrostomy (PEG) flexible feeding tube that cannot be managed independently;
- Stoma or Colostomy bags that cannot be managed independently;
- Catheters that cannot be managed independently.

12.1.2.2 Rule 5.8(b) reliance on the support or intervention of others

SRFC may look like a combination of these indicators but is not limited to:

Note: there is an overlap between self-management and self-care for people living with intellectual, psychosocial and cognitive impairments. If the evidence supports limited insight into caring for one's own self-care needs and the need for stand by assist for the majority of self-care tasks, then it meets the SRFC criteria.

- Evidence is needed for prescribed items such as stand by assistance or hands on support. There may be a need for a support person to lay out hygiene equipment (for example toothbrush, soap, face washer) and then talk the person through using each item.
- Evidence of fine motor difficulties is considered for SRFC in self- care. A condition that affect the fingers/upper limbs may affect the person's ability to complete fine motor self-care activities. Examples and further information of the supports needed

for upper limb/fine motor difficulties are available in the SRFC phone guide for question examples.

12.1.2.3 Rule 5.8(c) unable to participate in the activity

SRFC may look like but is not limited to:

The reliance on another person for 24/7 self-care support including overnight supervision or live in support of the person.

12.1.2.4 Psychosocial Disability

SRFC may look like but is not limited to:

- The person does not wash or change clothing without significant intervention;
- The person soils clothing or bedding and does not acknowledge need to wash/change soiled items;
- The person may have a lack of insight and requires intervention to manage health care needs.

12.1.2.5 Examples of what evidence may NOT meet the requirements of SRFC for Self Care

The below items are considered general items that are available in the community and are reasonable adjustments to living environments:

- Commodes
- Over-toilet seats
- Webster packs to track medication
- Shower chairs
- Slip-resistant mats
- Bath-Boards
- Modified cutlery
- Personal safety alarms
- Long handled brushes and pick up sticks
- Accessible tap handles
- Simple modifications to kitchen environment
- Sitting down to prepare meals
- Making use of microwave meals or Simple recipes
- Not being able to wash hair or cut toe-nails

- The independent use a catheter, stoma, colostomy bag or peg tube.

12.1.2.6 With regard to a psychosocial impairment, these examples alone are NOT considered to meet SRFC

- Needs periodic assistance to check compliance with medications.
- Shows limited interest in self-care and sometimes fails to wash and change clothes regularly.

**12.1.3 Learning**

12.1.3.1 Rule 5.8(a) reliance on prescribed aides and devices

A prescribed aide or device for learning would not meet SRFC. Specialised aides and devices are usually provided by the Education sector.

12.1.3.2 Rule 5.8(b) reliance on the support/intervention of others

SRFC may look like a combination of these indicators but is not limited to:

- Evidence the person get lost easily if they leave the house by themselves;
- An inability to implement road safety or maintain stranger danger awareness;
- Inability to learn a new bus route by themselves;
- They are part of an Australian Disability Enterprise (ADE);
- Unable to learn simple recipes or the process involved with other household tasks such as how to use a washing machine or dishwasher;
- Step by step instruction from another person is always required to learn a new task;
- A significant length of time is required to practice a new task before becoming independent or transferring the newly learned skill to a different environment;
- They may be an adult living at home who is unable to live independently;
- There may be guardianship or trustee orders in place or legal Authorised Representative acting on their behalf;
- Carers or support person plays a key role in all learning tasks required for community access. There may be an overlap with self- management;
- Verbal prompting may be required for all learning including a new morning routine, how to meet up with a new friend, how to travel to a new place.

12.1.3.3 Rule 5.8 (c) unable to participate in the activity

SRFC may look like but is not limited to:

There may be evidence of an inability to learn new tasks, remember information or practice a new skill. Formal or informal guardianship orders may be in place. There may also be overlap

with other key life areas such as self-management, mobility (for example, unable to learn to catch public transport), and social interaction.

12.1.3.4 Psychosocial Disability

SRFC may look like but is not limited to:

- Unable to learn a new bus route to get from home to work without assistance (not a substantial reduction, if it is age appropriate for assistance to be required).
- Unable to learn simple tasks such as how make a sandwich or a very basic meal.

12.1.3.5 Examples of what evidence may NOT meet the requirements of SRFC for learning. Please note these also apply to the area of psychosocial disability.

- Requiring an aide in school or TAFE. This support is provided through the Education setting. NDIS does not teach reading, writing and arithmetic;
- Needing electronic phone reminders to attend TAFE, School or University;
- Attendance issues relating to school TAFE or university;
- Lack of organisation or preparation skills to hand in school, TAFE or University assignments;
- The need for education adjustments within the School, TAFE or University setting.

**12.1.4 Self-Management**

12.1.4.1 Rule 5.8(a) reliance on prescribed aides and devices

SRFC may look like but is not limited to:

The combination of standby support or physical prompting to use common items such as; simple memory supports- diaries, calendars, alarms and reminders, Webster packs for medication, direct debit arrangements, lists to remember tasks, personal safety alarms. Usually common items used in isolation would not meet the SRFC requirements. Please proceed with caution and discuss with your Line Manager or TAB advisor.

12.1.4.2 Rule 5.8 (b) reliance on the support/intervention of others

SRFC may look like a combination of these indicators but is not limited to

- The person consistently has trouble-managing money and requires others to help;
- There may be a history of risk of financial and/or physical exploitation;
- Community Treatment Orders (CTO) may be in place;
- Medication non-compliance or poor insight into taking medication may be evident;
- There may be evidence of poor insight to manage health care needs appropriately;
- There may be evidence of guardianship orders, informal/formal care arrangements;

- Public trustee may be involved with management of finances;
- The person may be living in supported accommodation (formal / informal) or a supported independent living (SIL) environment;
- Strong evidence of Hoarding and Squalor leading to tenancy or health risk;
- Inability to live at home safely by themselves. Carers are required to monitor regular and safe use of kitchen appliances;
- Inability to solve a problem if they were out in the community by themselves. For example, how to calculate change accurately, what to do if they miss the bus;
- Limited insight into the value of money;
- A history of or risk of homelessness;
- There may be a dual diagnosis of a psychosocial disability and an intellectual disability;
- The person may not be able to handle planning their day by themselves or organising their time;
- The person may require the support of a carer to make all decisions regarding finances, health or housing.

12.1.4.3 Rule 5.8(c) unable to participate in the activity

There may be evidence of an inability to self-manage one's own life. Formal/informal guardianship orders may be in place. The person may be residing in supported accommodation or be an inpatient requiring support with all self- management. There may also be overlap with other key life areas such as learning.

12.1.4.4 Psychosocial Disability

SRFC may look like but is not limited to:

- Repeat homelessness as unable to manage a tenancy and make good decisions;
- Unable to manage finances;
- Hoarding has become a health and safety concern. No insight to manage the household.

12.1.4.5 Examples of what evidence may NOT meet the requirements of SRFC for learning. Please note these also apply to the area of psychosocial disability.

- The person is prone to poor financial decisions (has been known on occasion to spend entire weekly income on new clothes leaving nothing for bills and food) but this is not always the case;
- Lack of motivation to clean the house or inability to complete household chores;

- Simple aides and supports used independently without support from another person;
- Simple memory supports- diaries, calendars, alarms and reminders used independently;
- Medications - Webster packs, pharmacist supports;
- Direct debit arrangements;
- Lists to remember tasks;
- Personal safety alarms.

**12.1.5 Communication**

12.1.5.1 Rule 5.8(a) reliance on prescribed aides and devices

SRFC may look like but is not limited to:

- Adaptive computer equipment such as screen readers for example, “JAWS”, magnifiers.
- Augmentative and Alternative Communication (ACC) Devices for example, Proloquo2go, or text to speech software programs, picture exchange system such as PECS or boardmaker or commpics.

12.1.5.2 Rule 5.8(b) reliance on the support/intervention of others

SRFC may look like a combination of these indicators but is not limited to:

- The person is unable to express basic needs and wants without the support of another person;
- The person is unable to communicate with members of the community without the support of another person;
- The person cannot follow the rules of a conversation;
- Frequent communication breakdowns where the message is unable to be verbalised or understood resulting in a behavioural response outside the limits of community expectations;
- Unable to follow a 2-step verbal instruction without repetition;
- Unable to follow verbal instructions at work and require additional support from another person to understand;
- Unable to follow the rules of a community sporting group and require both pictures and the support of another person in order to understand;
- The person is “non-verbal” and is reliant on the support of another person to interpret gesture, signs or eye movements;

- The person only has a few verbal words. For example yes, no, toilet or more.

12.1.5.3 Rule 5.8(c) unable to participate in the activity

There may be evidence of an inability to communicate or the person is “non-verbal”. Formal or informal guardianship orders may be in place. The person may be residing in supported accommodation or be an inpatient requiring support with all communication. There may also be overlap with other key life areas such as learning, self- management.

12.1.5.4 Psychosocial Disability

Examples of SRFC:

- Passive behaviour (involving mainly yes or no answers) with no or very limited conversation and no initiation of conversation.
- Auditory hallucinations or thoughts interrupting communication attempts. The person may interrupt, shift topic, or have a separate conversation.
- Other cognitive or intellectual impairments that need the support of another person to manage behaviours.

12.1.5.5 Examples of what evidence may NOT meet the requirements of SRFC for communication. Please note these also apply to the area of psychosocial disability.

- A learning disorder which limits a persons’ ability to read and write;
- Attending speech pathology for help with communication;
- Help for remembering information at appointments;
- Support and prompting to share feelings.

**12.1.6 Case Studies in Communication – other key indicators**

12.1.6.1 Apraxia of Speech

Apraxia of speech (often referred to as Childhood Apraxia of Speech ‘CAS’) is a motor speech disorder. This is a neurological impairment commonly diagnosed by a Neurologist and/or Speech Pathologist. The TAT have advised IROs to consider Access Met – Early Intervention (section 24(1) (b), s251 (a) satisfied) and support the gathering of further information if required and completing a functional call with relevant authorised health professional and/or a ‘request further information’ letter.

12.1.6.2 Stroke/Cerebrovascular Accident (CVA), Traumatic Brain Injury (TBI) or Acquired brain Injury (ABI), Hypoxic brain Injury with communication impacts

Pathways in the brain are responsible for both understanding (receptive language) and speaking (expressive language). Any impacts on the brain can affect these areas responsible for communication. There will usually be a speech pathologist report, neurologist report or rehab specialist report. Further information should be sought using a functional capacity

phone call or request for further information letter if there is evidence of one of these impairments related to brain injury and there is information another person is supporting most communication attempts. Advice from your Line Manager or TAT advisor may be needed, if you notice any of these key indicators.

12.1.6.3 Vision and Hearing Impairments

Have reference to the Our Guidelines - Applying to the NDIS when assessing visual and hearing impairments and obtain further information if the SRFC requirements are not met.

An application does not need to demonstrate the application from a Deaf or Hard of Hearing person would meet the List A or B requirements to meet the Section 24 Disability Requirements. For example if a case shows the use of Cochlear implants and Auslan is the primary language, do not request further evidence in terms of audiograms or surgical reports if the functional evidence is demonstrating substantially reduced functional capacity.

The same is considered for visual impairments. An IRO can apply discretion around whether guide dogs, white cane, legally blind is mentioned in the evidence coupled with strong functional information rather than request evidence from an ophthalmologist. If in doubt, have a conversation with your Line Manager or receive further advice thought TAT.

Other key indicators to consider for vision and hearing impairments may include:

- Braille
- Hearing loss at a young age, now an adult and still reliant on aides
- Audiogram where the hearing limits do not reach the levels adequate for speech sound discrimination

**12.1.7 Social interaction**

12.1.7.1 Rule 5.8(a) reliance on prescribed aides and devices

SRFC may look like but is not limited to:

It is rare a person would be completely reliant upon a device for social interaction. There may be an overlap with a communication device, which the person uses when in social settings.

12.1.7.2 Rule 5.8(b) reliance on the support/intervention of others

SRFC may look like a combination of these indicators but is not limited to:

- History of inappropriate behaviours towards others;
- History of violent aggression where the person consistently misinterprets the responses of others;
- The person usually requires people to act as intermediary between them and others;

- The person's main social engagement is through facilitated and/or supported groups. For example day programs, social clubs;
- The person's parents may still organise their outings as an adult;
- The person's friends are mainly others people living with a disability or are trusted support workers;
- Evidence the person cannot make or keep friends;
- The person might regularly lose friends easily;
- The person may overshare to the point of vulnerability or offence;
- The person may not be able to access their community effectively due to a lack of ability to behave within social norms;
- There may be a history of being taken advantage of socially or a history of being socially vulnerable.

12.1.7.3 Rule 5.8(c) unable to participate in the activity

SRFC may look like but is not limited to:

There may be evidence of a complete inability to participate in the mainstream community appropriately. There may also be overlap with other key life areas such as learning, self-management.

12.1.7.4 Psychosocial Disability

Examples of SRFC in social interaction.

- The person may not be able to interact with members of the community due to social anxiety. They may require a support person to leave the house and interact with people at the bank, shop or post office;
- An inability to make and keep any friends;
- An inability to access any section of the community;
- An inability to behave within limits which are acceptable within the community.

12.1.7.5 Examples of what evidence may NOT meet the requirements of SRFC for communication. Please note these also apply to the area of psychosocial disability.

- Needs help to make contact with friends or socially withdraws when unwell;
- Only has contact with friends via phone, email;
- Socially isolated because friends and family live far away;
- Socially isolated because they are a person from a culturally and linguistically diverse background (CALD).

## 13. Supporting material

- NDIS Act 2013.
- NDIS Rules 2016 (Becoming a Participant).
- Our Guidelines - Applying to the NDIS.
- Complete an Access or Revocation Internal Review Decision Standard Operating Procedure.

## 14. Process owner and approver

Branch Manager, Internal Reviews and Complaints Branch.

## 15. Feedback

If you have any feedback about this Practice Guide, please complete our Internal Review Team Quality and Continuous Improvement Form and email it to the Business Improvement Team. In your email, remember to include the title of the product you are referring to and describe your suggestion or issue concisely.

## 16. Version change control

| Version No | Amended by | Brief Description of Change | Status | Date |
|---|---|---|---|---|
| 1.0 | BC0038 | New Guidance | APPROVED | 2020-10-07 |
| 2.0 | DII394 | Class 1 Approved. | APPROVED | 2020-11-27 |
| 3.0 | MC0104 | Review of PG - Remove 3 Tier process and replace with Option 1 and 2 process. Class 1 approval | APPROVED LW0022 | 2021-10-05 |
| 4.0 | LW022 | Review of PG Consistent wording guidance for where s24 (1) (e) not satisfied for alternate support contacts. Minor amendments based on feedback KB0073 and SW0065. | APPROVED KMO722 KH0021 | 2022-04-05 |

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|---|---|---|---|---|
| | | Updates to wording based on NDIA terms guide. | | |
| 5.0 | LW0022 | Based on CI Reg #191 wording drafted to include guidance where SRFC not satisfied due to nil evidence provided. Updates for Applying to the NDIS. Applying to the NDIS provides greater clarity and transparency around our eligibility requirements and decision-making processes. Structure and language is now easier to understand and navigate. Applying to the NDIS has replaced the Access to the NDIS Operational Guideline when it is published on the NDIS website (external). | APPROVED SW0065 | 2022-06-06 |