EXAMPLE OT SERVICES

Occupational Therapy · NDIS Registered Provider

Victoria, Australia

OCCUPATIONAL THERAPY REPORT

Home & Living Assessment

A Supported Independent Living (SIL) assessment of functional capacity, support needs and reasonable and necessary supports.

PREPARED FOR Mr. A · SIL Home & Living Assessment

Sample report. All participant details have been changed and are fictitious. Prepared for NDIS purposes.

This report provides:

- An Occupational Therapy assessment summary of Mr. A's functional capacity.
- Recommendations regarding Mr. A's SIL requirements.
- Recommendations about Occupational Therapy interventions to assist Mr. A in working towards his goals and aspirations.
- Recommendations regarding Mr. A's general support and capacity building needs.

Personal Details

Full Name:	Mr. A
Date of Birth:	[DOB] – 26 years
NDIS#:	000 000 000
Address:	XYZ Street, [Suburb], VIC
Referrer:	[Support Coordinator] – [Service Provider]
Date of Report:	[Date]

REASON FOR REFERRAL

Mr. A was referred by his support coordinator for a comprehensive Occupational Therapy Home and Living Assessment to assess his current functional capacity, support needs, and eligibility for Supported Independent Living (SIL).

DISCLAIMER

This report reflects our clinical opinion based on the information provided at the time of the assessment and is written to the author's best knowledge. The author reserves the right to review this report and its findings if additional clinical information is provided.

The author acknowledges that the following document contains deficit-based and non-neurodiversity affirming language and themes. We regret that this may cause or contribute to distress or feelings of shame. The current disability system continues to allocate funding using a deficit-based model. This document has been produced to ensure our client can receive every support they may be eligible for based on disability criteria.

CLIENT INFORMATION

Introduction

Mr. A is a 26-year-old man who currently resides with his ageing parents in the family home in [Suburb], VIC. Mr. A has lived in the family home his entire life. His parents, both in their late 60s, have been his primary carers since birth and are currently experiencing significant physical health challenges that have substantially reduced their capacity to continue providing the level of support Mr. A requires.

Mr. A is a sociable and good-natured young man who enjoys interacting with familiar people and engages positively with structure and routine. He demonstrates a genuine desire to connect with others and to participate in activities within his community; however, due to his disability, he requires substantial support and guidance across all areas of daily living.

Interests

Mr. A enjoys listening to music, watching his favorite television programs, and going for walks in familiar local environments. He particularly enjoys outings to the local shops and cafes when supported and responds positively to community-based activities that incorporate social interaction and predictable structure. Mr. A has expressed an interest in attending a day program or structured activity group to expand his social connections and engagement in meaningful activities.

Culture & Family

Mr. A lives within a close-knit family unit. His parents have been his primary carers throughout his life and remain strongly committed to his wellbeing. However, both parents are currently managing their own significant health conditions, and the level of care they are able to provide has decreased considerably over the past 12 months.

Mr. A's father has recently been diagnosed with a significant cardiac condition and has been medically advised to reduce physical exertion. Mr. A's mother manages chronic pain associated with osteoarthritis, which limits her physical capacity to assist with his personal care and domestic support needs. The family has expressed significant concern regarding the long-term sustainability of their caring role and the urgent need for formalised support arrangements.

Mr. A has one older sister who resides interstate with her own family. While she maintains regular phone contact with the family, she is unable to provide direct ongoing care due to geographical distance and her own family commitments.

Disability Profile

Mr. A has a disability that substantially impacts his daily functioning. Mr. A's disability profile includes the following diagnoses:

- Autism Spectrum Disorder (ASD) – Level 2
- Intellectual Disability – Mild to Moderate

Autism Spectrum Disorder (ASD) Level 2 indicates that Mr. A requires substantial support across all areas of daily functioning. His ASD significantly impacts his social communication, capacity to manage transitions and unexpected changes, emotional regulation, and engagement in community and daily living activities.

Intellectual Disability (Mild to Moderate) refers to significantly below-average intellectual functioning alongside substantial limitations in adaptive behaviour, affecting conceptual, social, and practical skills. For Mr. A, this means he requires structured support, simplified information, and consistent prompting to manage all aspects of daily living, learning, and community participation.

Co-occurring Health Conditions

Mr. A also presents with mild anxiety, particularly in unfamiliar environments or when routines change unexpectedly. He has no significant physical health conditions at this time.

Current Treatment & Interventions

Mr. A is currently receiving the following supports:

- Occupational Therapy – [Provider]
- Support Coordination – [Name], [Provider]
- GP management – [Name], [Clinic]

Support Networks

Formal Supports:

- Support Coordinator – [Name], [Provider]
- GP – [Name], [Clinic]

Informal Supports:

- Mother – primary carer; assists with all personal care, domestic tasks, medication management, community access, and daily routine management.
- Father – provides physical assistance where able; however, his capacity has significantly reduced following his recent cardiac diagnosis.
- Older sister – resides interstate; provides emotional support via phone but cannot provide direct ongoing care.

Barriers to Accessing/Utilising Supports

Mr. A requires significant support to understand and engage with services. Due to his intellectual disability, he requires all information to be presented in simplified language with visual supports. He can become anxious and resistant when introduced to unfamiliar people or environments, requiring a gradual and supported approach to service engagement.

Participant Decision Maker

Mr. A makes decisions with the support of his parents. His parents are actively involved in all significant decision-making related to his care, supports, and living arrangements.

ASSESSMENT METHODS

The following activities were undertaken to conduct this functional capacity assessment:

- World Health Organisation Disability Assessment Schedule 2.0 (WHODAS 2.0) – proxy rated by mother
- Health of the Nation Outcome Scales (HoNOS) – completed by writer on Mr. A's behalf
- Abbreviated Life Skills Profile (LSP-16) – completed by writer on Mr. A's behalf
- In-person visits on [Date] and [Date]
- Informal functional assessment and observation in Mr. A's home and community environment
- Interviews and consultations with Mr. A's mother
- Review of NDIS plan and referral documentation

STANDARDISED ASSESSMENT OUTCOMES

World Health Organisation Disability Assessment Schedule 2.0 (WHODAS 2.0)

The WHODAS 2.0 is a generic assessment instrument for health and disability. It produces standardised disability levels and profiles applicable across cultures, in all adult populations, directly linked at the level of the concepts to the International Classification of Functioning, Disability and Health (ICF).

The WHODAS 2.0 was completed by Mr. A's mother as proxy on [Date]. Higher scores indicate greater disability.

WHODAS Domain	Score (1–5)	Level of Impact
Cognition – Understanding / Communicating	4	Extreme Difficulty
Mobility – Getting Around	2	Moderate Difficulty
Self-care – Taking Care of Yourself	4	Extreme Difficulty
Getting Along with People	4	Extreme Difficulty
Life Activities – Household Activities	4	Extreme Difficulty
Life Activities – Work or School Activities	5	Cannot Do

WHODAS Domain	Score (1–5)	Level of Impact
Participation in Society	4	Extreme Difficulty

Health of the Nation Outcome Scales (HoNOS)

The HoNOS is a clinician-rated instrument comprising 12 simple scales measuring behaviour, impairment, symptoms, and social functioning for adults aged 18–64. Mr. A was evaluated using the HoNOS on [Date].

HoNOS Domain	Score (0–4)
Overactive, aggressive, disruptive or agitated behaviour	2
Non-accidental self-injury	1
Problem drinking or drug-taking	0
Cognitive problems	3
Physical illness or disability problems	1
Problems associated with hallucinations and delusions	0
Problems with depressed mood	1
Other mental and behavioural problems	2
Problems with relationships	3
Problems with activities of daily living	4
Problems with living conditions	2
Problems with occupation and activities	4

Domain	Item Score	Subscale Score
Behavioural Problems		3/12
Impairment		4/8
Symptomatic Problems		3/12
Social Problems		13/16
Total Score		23/48

Mr. A’s HoNOS results indicate significant functional impairment across cognitive, daily living, social, and occupational domains, consistent with his ASD Level 2 and Intellectual Disability diagnoses.

Abbreviated Life Skills Profile (LSP-16)

The LSP-16 is a 16-item measure of life skills and functional disability in people with disability. Each item is scored 0–3. Lower scores indicate higher functioning. Total possible score is 48. The writer completed this assessment on [Date] on Mr. A's behalf.

Domain	Item Score	Subscale Score
Withdrawal		8/12
Difficulty in conversation	2	
Withdraw from social contact	2	
Shows warmth	2	
Maintain friendships	2	
Self-Care		10/15
Well groomed	2	
Clean clothes	2	
Neglect health	2	
Adequate diet	2	
Work capability	2	
Compliance		4/9
Look after own prescribed medication	2	
Willing to take prescribed medication	1	
Co-operate with health services	1	
Anti-Social		4/12
Violent	1	
Problems with others	1	
Offensive behaviour	1	
Irresponsible behaviour	1	
Total Score		26/48

IMPACT OF DISABILITY ON DAILY FUNCTIONING

Communication

Evidence
As per standardised assessment outcomes As per reports provided As observed by the writer As reported by the participant's mother

Mr. A presents with significant disability-related communication support needs across both receptive and expressive domains. Due to his intellectual disability and ASD, he requires substantial support to understand, process, and respond to information across both structured and informal environments.

Mr. A's receptive communication is impacted by support needs with attention, concentration, and speed of information processing, often resulting in delayed or incomplete understanding of verbal instructions. He requires simplified language, repetition, visual supports, and instructions broken down into clear, one-step components to support comprehension. Mr. A's mother reported that he frequently nods or agrees without fully understanding what has been said, particularly when he is anxious or overwhelmed.

Mr. A's expressive communication is also significantly impacted by his disability. While he communicates verbally, he requires substantial support to articulate his needs, thoughts, and emotions in a clear and organised manner. Due to his significant intellectual disability, he requires significant support to explain concepts, particularly when under stress, and often requires prompting and visual supports to express himself effectively.

Mr. A demonstrates significantly limited reading and writing abilities and has not developed functional literacy skills. He is unable to engage in tasks requiring reading or written communication and relies heavily on verbal, visual, and practical supports to access information. This significantly impacts his ability to manage daily responsibilities, including remembering appointments, understanding written instructions, and engaging in structured tasks without support.

Mr. A requires consistent, structured, and supportive communication approaches to ensure his needs are understood and appropriately responded to. Ongoing capacity-building strategies are essential to support the development of his communication skills, improve his ability to regulate his responses, and enhance his overall participation and engagement in daily activities.

Social Interaction

Evidence
As per standardised assessment outcomes As per reports provided As observed by the writer As reported by the participant's mother

Making and Keeping Friends

Mr. A presents with significant capacity-building needs in developing and maintaining meaningful friendships. Despite a strong desire for social connection, his ASD-related social communication differences and limited opportunities for peer interaction throughout his life have significantly impacted his ability to form stable and reciprocal relationships.

Mr. A's social network is currently limited to his immediate family. He has no peer friendships at this time and minimal exposure to age-appropriate social environments. Mr. A demonstrates a warm and friendly demeanour with familiar people; however, he requires substantial support to navigate unfamiliar social interactions and to understand social rules, mutuality, and boundaries.

Mr. A would benefit from structured, supported opportunities for safe social engagement. Interventions should focus on developing his social understanding, communication skills, and confidence in age-appropriate social contexts, while ensuring environments are supportive, predictable, and facilitated by trusted support workers.

Interacting with Peers or the Wider Community

Mr. A demonstrates limited capacity to engage with peers and the broader community. His participation in social and community environments has been substantially restricted due to his disability profile and the absence of formal support to facilitate community access. His mother reports that community outings are infrequent and largely centred around shopping or appointments rather than meaningful social engagement.

Despite these deficits, Mr. A demonstrates positive engagement when supported appropriately. He responds well to familiar support workers, structured activities, and interest-based community outings. Mr. A requires structured, one-on-one support to safely engage in community settings. Gradual exposure, consistent routines, and guided participation are essential to build his confidence, reduce vulnerability, and promote meaningful inclusion in community life.

Coping With Related Feelings and Emotions

Due to significant disability, Mr. A requires substantial support in understanding, expressing, and regulating his emotions. He demonstrates limited emotional awareness and requires consistent support to process and manage internal experiences, particularly during periods of stress or routine disruption.

Mr. A's mother reported that he can become highly distressed when routines change unexpectedly or when he is exposed to unfamiliar environments. During these periods, he may withdraw, become tearful, refuse to engage with tasks, or display behavioural escalation including raised voice, repetitive behaviours, and self-soothing behaviours such as rocking or hand-flapping. These responses are understood to be disability-related expressions of distress rather than deliberate misconduct; however, they significantly impact his ability to engage in daily activities and require structured support to manage safely.

Mr. A requires significant, structured, and ongoing support to develop emotional regulation and coping skills. This includes consistent routines, capacity-building strategies focused on emotional awareness and self-regulation, and a structured environment with predictable expectations and supportive guidance.

Learning New Skills

Evidence
As per standardised assessment outcomes As per reports provided As observed by the writer As reported by the participant's mother

Understanding and Remembering Information

Mr. A requires significant support to understand and retain information in his daily life. Due to his intellectual disability and ASD, he requires substantial support in processing, storing, and recalling information. Information provided to Mr. A needs to be concrete, highly simplified, and delivered in a clear and structured manner to support his understanding. He requires repetition, consistent verbal prompts, visual supports, and reminders to assist with retention and recall of information over time.

Mr. A displays a strong reliance on familiar routines and established patterns and requires significant capacity building to adapt to new or unfamiliar information without structured support. Without consistent reinforcement, he is likely to forget or misinterpret information, which can impact his ability to follow through with tasks, appointments, and daily expectations.

Practising and Using New Skills

Mr. A requires significant support to learn, practise, and generalise new skills. Due to significant executive functioning deficits, he requires significant assistance in initiating, sustaining, and completing tasks, particularly when they are unfamiliar or complex. When introduced to new skills, Mr. A requires clear, step-by-step instruction, simplified explanations, visual prompts, and ongoing reinforcement to support learning and application.

Observations indicate that Mr. A may become disengaged or anxious when tasks are perceived as difficult or unclear. He requires consistent prompting, reassurance, and structured guidance to remain engaged and to build confidence in skill development. Learning is most effective when delivered in structured, predictable environments, with consistent reinforcement and opportunities for repetition.

Mobility

Evidence
As per standardised assessment outcomes As per reports provided As observed by the writer As reported by the participant's mother

Motor Skills

Mr. A's motor skills are broadly within normal physical limits, with no identified physical deficits. He is independently ambulant and does not require any mobility aids. However, he presents with some disability-related issues impacting his ability to engage in tasks requiring sustained attention, coordination, and motor planning.

Mr. A demonstrates some clumsiness with fine motor tasks and reduced motor planning skills, consistent with his ASD profile. He requires support to engage in tasks requiring fine motor coordination such as managing buttons, zips, and shoelaces, and may require adapted equipment or simplified routines to support independence.

Community Access

Mr. A requires high levels of one-to-one support in community settings due to significant safety risks associated with his disability profile. While Mr. A enjoys community outings and shows preference for interest-based activities such as walking and visiting cafes, he requires constant supervision to ensure his safety in public environments.

Mr. A demonstrates limited road safety awareness, can become anxious in crowded or unpredictable environments, and is vulnerable to becoming overwhelmed or lost in unfamiliar settings. He has no awareness of stranger danger and is at risk of being taken advantage of due to his friendly and trusting nature. Mr. A also has limited capacity to seek help in an emergency or to identify an unsafe situation.

Mr. A requires consistent, structured, and supervised community access, with gradual exposure to a range of meaningful and interest-based activities to support engagement and reduce his vulnerability.

Self-Care

Evidence
As per standardised assessment outcomes As per reports provided As observed by the writer As reported by the participant’s mother

Mr. A is currently able to complete basic activities of daily living, including showering, grooming, dressing, toileting, and eating, with significant prompting, supervision, and guidance from his mother. He is physically capable of completing these tasks; however, his ability to perform them without external support is significantly impacted by his disability.

Due to his disability, Mr. A requires ongoing verbal prompting, supervision, and routine-based support to initiate and complete all self-care tasks. His mother plays a significant role in maintaining this structure by providing consistent reminders (e.g., prompting him to shower, change clothes, brush his teeth), preparing meals, and closely monitoring his daily routine, appointments, and overall functioning.

Without external prompting and supervision, Mr. A demonstrates reduced initiation, poor follow-through, and limited consistency in maintaining personal hygiene and daily routines. He may forget to complete tasks such as brushing his teeth or changing his clothes for several days at a time and requires consistent external reinforcement to maintain adequate hygiene.

Sleeping

Mr. A generally maintains an adequate sleep routine while residing in the structured environment of the family home. He follows a consistent bedtime routine supported by his mother. However, transitions or changes to his routine can disrupt his sleep, resulting in nighttime waking, anxiety, and reduced sleep quality. Mr. A's sleep is highly dependent on environmental stability and predictability.

Caring for Own Health

Mr. A requires substantial support to develop insight into his disability, the level of care he requires, and the importance of actively managing his own health. His disability significantly impacts his awareness, understanding, and engagement with health-related tasks. He is unable to independently recognise health concerns, seek medical attention, or follow medical recommendations without support.

Medication Management

Mr. A is not currently prescribed regular medication; however, when occasional medications are required, his mother manages all aspects of administration. Mr. A is unable to manage his own medications and requires full support in this area. If his medication needs change in the future, he will require ongoing medication management support from formal carers.

Managing Healthcare Needs

Mr. A's healthcare needs are currently managed by his mother, who coordinates and attends all medical appointments with him. His mother monitors his physical and emotional wellbeing and ensures appropriate care is sought when required. Mr. A requires one-to-one support to attend medical appointments and to communicate with healthcare professionals due to his communication and cognitive support needs.

Self-Management

Evidence
As per standardised assessment outcomes

As per reports provided
As observed by the writer
As reported by the participant's mother

Domestic Tasks

Mr. A requires consistent one-to-one support and structured verbal prompting to enhance his capacity to complete domestic tasks. Although he is physically capable of performing household activities, his disability significantly impacts his ability to initiate, follow through, and maintain a safe and functional living environment.

Mr. A's engagement in domestic tasks such as cleaning, tidying, laundry, meal preparation, and doing the dishes is inconsistent and largely dependent on prompting and support from his mother. He may assist his mother with simple tasks when prompted; however, this participation is not sustained and does not reflect independent functioning.

Due to his disability, Mr. A requires substantial assistance in key domestic areas. He has not developed the ability to initiate or complete laundry tasks independently and requires one-to-one support and step-by-step prompting. Similarly, he has not acquired adequate meal preparation skills and requires direct assistance to initiate and complete even basic cooking tasks. Mr. A is unable to safely use kitchen appliances such as the stove or oven without close supervision.

Mr. A requires ongoing intensive capacity-building intervention and routine-based support to develop domestic skills, improve task initiation and follow-through, and promote a safe, organised, and sustainable living environment.

Community Tasks

Mr. A requires significant support and structured capacity-building intervention to ensure that community access is both meaningful and safe. Due to the impact of his disability, alongside limited insight and reduced executive functioning, his ability to participate in community environments is substantially limited.

Mr. A requires substantial support across all community-based activities, including shopping, general community participation, and maintaining personal safety in public settings. He requires significant assistance with financial decision-making, particularly in distinguishing between essential and non-

essential items, as well as understanding value for money. This places him at risk of inappropriate spending and financial exploitation without appropriate supervision and guidance.

Mr. A also requires ongoing structured capacity-building strategies to support the development of safe community participation skills, including communication, decision-making, and appropriate social behaviour in public environments.

Money Management

Mr. A requires significant support and structured capacity-building intervention to develop a basic understanding of financial management. Due to the impact of his disability, his capacity to manage financial matters is substantially reduced, particularly in relation to understanding the concept of money, recognising the value of currency, budgeting, and prioritising essential expenses.

Mr. A's financial income is currently managed by his mother, who assists with the organisation and allocation of his Disability Support Pension to ensure essential expenses are met. Mr. A is unable to manage his own finances and is at significant risk of financial exploitation if not provided with structured support. Without appropriate oversight, he may be vulnerable to giving away money or being taken advantage of by others due to his trusting nature

Behaviours of Concern

Evidence
As per standardised assessment outcomes As per reports provided As observed by the writer As reported by the participant's mother

Mr. A presents with low-frequency behaviours of concern, which are primarily expressions of distress and overwhelm associated with his disability profile. His mother reports that these behaviours are infrequent and predictable, generally occurring in response to specific triggers such as routine changes, sensory overload, or unmet needs.

Behavioural presentations include:

- Verbal escalation – raised voice, repetitive vocalisations, and refusal phrases when distressed.

- Withdrawal – retreating to his room, refusing to engage, and avoidance of preferred activities.
- Self-soothing behaviours – rocking, hand-flapping, and repetitive movements during periods of distress.

Mr. A does not have a history of physical aggression toward others or property destruction. However, without consistent and predictable support, his behavioural presentation may escalate as he is exposed to greater environmental change and unmet support needs. A Behaviour Support Plan (BSP) is recommended to formalise strategies and ensure consistent support across environments.

HOME AND LIVING ASSESSMENT

The housing and support model most suitable for Mr. A is based on a safe environment, safe and predictable supports, and a daily/weekly structure and routine with incorporated meaningful activities. This forms the basis on which capacity-building can occur.

Eligibility – Supported Independent Living (SIL)

Participant's Goals and Aspirations

Mr. A's goals as per his current NDIS plan are:

- I would like to learn skills to look after myself in the future when my parents can no longer help me.
- I want to live with friendly people who can support me every day.
- I want to go out into the community and do things I enjoy.
- I would like to develop friendships with people my own age.
- I want to be able to look after my own room and help with cooking.
- I want to attend a day program or structured activity group.

Current Living Situation

Mr. A currently resides in the family home in [Suburb], VIC, with his parents. He has lived in this home his entire life and is closely attached to the familiar environment, routines, and family members. The home is a three-bedroom standalone property that has been adequately set up to accommodate Mr. A's needs to date.

However, the current living arrangement is no longer sustainable due to the significant decline in his parents' capacity to provide care:

- Mr. A's father (aged 68) has recently been diagnosed with a significant cardiac condition and has been medically advised to avoid lifting, physical exertion, and stress. He is no longer able to assist with Mr. A's physical care or behavioural management.
- Mr. A's mother (aged 66) manages chronic osteoarthritis affecting her hands, knees, and back. She has reported increasing pain and fatigue and is no longer able to manage the physical demands of caring for Mr. A on a sustained daily basis.
- Both parents have expressed significant concern about their ability to continue providing care into the future and have expressed a clear desire to plan for Mr. A's long-term living arrangement now, while they are still able to support a planned and gradual transition.

Sustainability/Suitability of Current Living Situation

The current living arrangement is not considered suitable or sustainable to meet Mr. A's ongoing and escalating support needs. The full burden of his care has been managed informally by his ageing parents, who are both experiencing significant and worsening health conditions that have substantially reduced their capacity to provide the level of care Mr. A requires.

Mr. A requires consistent supervision, structured routines, prompting and physical assistance with all areas of daily living, which cannot be sustainably provided by his parents alone going forward. There is significant carer fatigue and burnout, and the family is at risk of crisis breakdown if formal support is not implemented in a structured and timely manner.

Mr. A is also significantly at risk in the medium to long term if his parents experience further health deterioration. He has no other informal carers available to step in, and his sister resides interstate. Implementing a planned and supported transition to a SIL arrangement now will reduce the risk of an unplanned crisis transition in the future, which would be highly distressing for Mr. A and detrimental to his functional capacity and wellbeing.

Sustainability/Suitability of Current Support Situation

Mr. A is currently linked with formal support coordination and occupational therapy; however, the bulk of his daily support is provided informally by his parents. This support model is fragmented and informal-heavy and is insufficient to provide the level of consistency, structure, and active supervision

required to support safe functioning across daily living, community participation, and skill development.

Formal supports are not currently delivered within a consistent 24/7 framework, limiting their ability to proactively manage Mr. A's daily needs, implement behaviour support strategies in real time, and provide continuous capacity-building within daily routines.

Participant's Housing History

The following housing history was established with Mr. A and his family:

Setting	Duration	Reasons for Cessation
Family home with parents in [Suburb], VIC	Birth – Present (26 years)	Ongoing; however, no longer sustainable due to parents' declining health and capacity to provide care.

Alternative Home and Living Options Considered

The writer considered the following alternative housing options:

Housing & Living Option	Suitable	Clinical Reasoning
Continue Living with Parents (Current Arrangement)	No	Not suitable or sustainable in the medium to long term due to the significant decline in his parents' health and capacity to provide care. Both parents are managing chronic health conditions that limit their capacity to continue providing the level of physical, supervisory, and behavioural support Mr. A requires. Continuing this arrangement places Mr. A at significant risk of unplanned crisis transition should his parents experience further health deterioration. A planned, supported transition while parents are still able to participate is essential.
Private or Public Rental	No	Mr. A does not have the functional capacity, insight, or independent living skills required to manage a tenancy. Due to his intellectual disability and ASD, he demonstrates substantial support needs in all areas of daily living and is unable to manage responsibilities such as maintaining the property, paying bills, adhering to tenancy obligations, and sustaining a safe living environment. A standard rental environment does not provide the level of supervision, structure, or capacity-building support required to ensure Mr. A's safety or stability.
Specialist Disability	No	Mr. A does not present with significant physical or functional

Housing & Living Option	Suitable	Clinical Reasoning
Accommodation (SDA)		impairments requiring specialised housing design or assistive infrastructure. His primary support needs are related to intellectual disability, ASD, behavioural and capacity-building support rather than environmental modifications. Therefore, SDA is not considered a reasonable or necessary support.
Supported Residential Service (SRS)	No	An SRS setting would not be appropriate for Mr. A as it typically provides a custodial model of care with limited focus on individual capacity building. These environments often restrict autonomy and do not consistently provide structured capacity-building interventions required for individuals with complex needs. Mr. A requires active, skill-building support to develop independence in daily living, communication, and community participation, which is not aligned with the passive support model of SRS.
Living Independently with Outreach Supports	No	Mr. A is not able to safely live independently with outreach or drop-in supports due to the severity of his functional impairments. He requires consistent supervision, structured routines, and real-time support to manage daily living tasks, communication, decision-making, and safety. Outreach supports would not provide the intensity or responsiveness required to ensure Mr. A's safety, prevent harm, or support engagement in daily living tasks. This model would place Mr. A at significant risk of harm, neglect, and disengagement.
Supported Independent Living (SIL)	Yes	Supported Independent Living is the most appropriate and least restrictive option for Mr. A. A SIL model would provide 24/7 structured support, active supervision, and a predictable environment necessary to manage his disability-related support needs. It would enable consistent implementation of capacity-building strategies, support communication and emotional regulation, and facilitate skill development in daily living, community participation, and social engagement. SIL would also reduce reliance on Mr. A's ageing parents and address current carer burden, providing a sustainable long-term living solution aligned with his goals and support needs.

Participant's Functional Skills and Potential to Build on These

Within a suitable living environment, Mr. A is able to build on his daily living skills with consistent assistance and support of capacity-building and direct supports. This includes the following areas:

- Mobility
- Communication
- Social Interaction
- Self-Management

- Learning
- Self-Care

NDIS ACT 34 – REASONABLE AND NECESSARY SUPPORTS

Section 34 of the NDIS Act requires the CEO to be satisfied of all of the following in relation to the funding of supports:

(a) The support will assist the participant to pursue the goals, objectives and aspirations included in the participant's statement of goals and aspirations; and (b) the support will assist the participant to undertake activities, so as to facilitate the participant's social and economic participation:

To achieve his stated goals, Mr. A requires 24/7 Supported Independent Living (SIL) with structured and consistent support. Due to his ASD Level 2 and Intellectual Disability, Mr. A demonstrates reduced capacity in all areas of daily functioning, communication, learning, decision-making, and independent functioning. This level of support will assist Mr. A to build the foundational skills required to engage in daily living tasks, develop communication and social skills, and increase participation in meaningful and structured activities. With consistent supervision and support, Mr. A will be able to gradually engage in skill-building opportunities such as domestic tasks, community participation, and a day program aligned with his interests.

(c) The support represents value for money in that the costs of the support are reasonable, relative to both the benefits achieved and the cost of alternative support:

Mr. A requires a high level of daily support due to the complexity of his needs, including substantial assistance with daily living tasks, communication, supervision, and emotional regulation. A SIL model allows for shared supports where appropriate, making it a cost-effective option compared to intensive one-to-one outreach supports or repeated crisis interventions. Alternative models such as living independently with outreach supports are not appropriate, as they would not provide the level of supervision and structure required to manage risks associated with Mr. A's disability. This would likely result in increased long-term costs due to crisis responses, hospitalisation, or breakdown of informal supports.

(d) The support will be, or is likely to be, effective and beneficial for the participant, having regard to current good practice:

Current best practice for individuals with similar profiles to Mr. A includes structured supported living environments with consistent routines, active supervision, and integrated capacity-building supports. For a young adult like Mr. A, transitioning into a supported living environment is a developmentally appropriate step. It promotes independence while ensuring safety and stability, particularly given his disability profile and the significant decline in informal carer capacity.

(e) The funding or provision of the support takes account of what it is reasonable to expect families, carers, informal networks and the community to provide:

Mr. A has been primarily supported by his parents throughout his life. However, this arrangement is no longer sustainable due to his parents' significant health conditions and reduced capacity to continue providing the level of care Mr. A requires. It is not reasonable to expect his parents to continue providing the intensive level of supervision, prompting, and physical assistance required on an ongoing basis. The current reliance on informal supports places both Mr. A and his parents at risk of carer breakdown and crisis transition. Mr. A's family will continue to play an important role in his life by providing emotional support, maintaining relationships, and participating in significant life events. However, formal supports are required to meet his daily functional and safety needs within a structured living environment.

(f) The support is most appropriately funded or provided through the National Disability Insurance Scheme:

Mr. A's support needs are directly related to his ASD Level 2 and Intellectual Disability, which significantly impact his communication, social interaction, daily living, self-care, and self-management. These needs are not appropriately met through mainstream or community services, as they require specialised, disability-specific supports delivered within a structured and supervised environment. Therefore, these supports are most appropriately funded through the NDIS.

Support Model

The most appropriate support model for Mr. A is Supported Independent Living (SIL) with 24/7 support.

Due to the combined impact of his ASD Level 2 and Intellectual Disability, Mr. A requires substantial support and capacity building in communication, daily living, decision-making, emotional regulation, and community access. These impairments significantly limit his ability to safely manage daily living tasks, make appropriate decisions, and respond adaptively to environmental demands without continuous support.

Mr. A requires constant person-to-person support and cannot be safely left alone for extended periods of time. During periods of distress or routine disruption, he demonstrates reduced capacity to self-regulate, and he is significantly vulnerable in unsupervised settings due to limited insight, social vulnerability, and reduced safety awareness.

A shared onsite support model will provide:

- Continuous supervision to mitigate risks related to safety, vulnerability, and reduced insight.
- Structured and predictable routines to support cognitive functioning and reduce anxiety.
- Immediate, responsive support to manage emotional distress and behavioural responses.
- Opportunities for supported social interaction to address social isolation and build interpersonal skills.
- Consistent implementation of capacity-building strategies within a real-life environment.

Level of Support

Mr. A would be suitable for a shared SIL arrangement (e.g., 1:3 ratio) with carefully matched co-residents who have compatible support needs and behavioural profiles. He responds well to predictable, structured environments and would benefit from sharing a home with co-residents who are similarly engaging and friendly.

- 1:3 Support: One support worker for three participants – for shared in-home supports across the day, including assistance with personal care, domestic tasks, meal preparation, and structured activities.
- 1:1 Support: One support worker for one participant – for individual community access activities, attendance at appointments, and day program participation, due to Mr. A's vulnerability and need for individual supervision in community settings.

Intensity of Support

Mr. A requires standard intensity support. He does not currently require high-intensity supports as his behaviours of concern are low-frequency and predictable. However, his support needs are substantial across all domains of daily living and require consistent, structured input.

Irregular Support

As per his standard support needs, Mr. A requires up to 10 irregular support days per year for unexpected or unplanned situations.

SIL Timetable

Mr. A's support needs are illustrated in the SIL timetable below.

Time	Support Required
7:00 am	1:3 – Support with waking, orientation to the day, and reassurance.
7:30 am – 8:30 am	1:3 – Assistance with personal care (showering, grooming, dressing) and prompting through the morning routine. Mr. A requires step-by-step verbal prompts and supervision.
8:30 am – 9:00 am	1:3 – Breakfast preparation, eating, and clean-up. Visual schedules used to support routine.
9:00 am – 9:30 am	1:3 – Daily planning, visual scheduling, and preparation for the day's activities.
9:30 am – 12:30 pm	1:1 – Community access and day program attendance (e.g., structured day program, interest-based community activities, social skills groups). 1:1 support required due to Mr. A's vulnerability and supervision needs in community.
12:30 pm – 1:30 pm	1:1 – Lunch and transition back home.
1:30 pm – 3:30 pm	1:3 – Capacity-building activities in the home (e.g., laundry, simple cooking tasks, organising personal items) with step-by-step prompting and supervision.
3:30 pm – 5:00 pm	1:3 – Afternoon activities (preferred leisure activities, music, walks) and rest periods to support regulation.
5:00 pm – 6:30 pm	1:3 – Capacity-building support with dinner preparation, eating, and clean-up.
6:30 pm – 8:30 pm	1:3 – Evening leisure activities, social interaction with co-residents, and engagement in preferred activities.
8:30 pm – 9:30 pm	1:3 – Wind-down routine, evening personal care, medication if required, and preparation for bed.
9:30 pm – 10:00 pm	1:3 – Settling for bed, including verbal reassurance and prompting through the bedtime routine.

Overnight Support (10:00 pm to 7:00 am)

Sleepover/inactive overnight support is appropriate for Mr. A.

Mr. A generally sleeps through the night when his routine and environment are stable. He does not require active overnight support at this stage. However, sleepover support is required to:

- Respond to any nighttime waking, distress, or anxiety.
- Provide reassurance during periods of routine adjustment, particularly during the transition into SIL.
- Manage any medical or safety concerns that may arise overnight.
- Ensure prompt support is available at the start of the morning routine.

PLANNING OF OT CAPACITY-BUILDING SUPPORT

OT Goals

The writer identified the following OT goals for Mr. A:

- Establish and implement a consistent weekly routine with a strong focus on capacity building to support Mr. A's engagement in daily activities, improve task initiation and follow-through, and promote stability across environments.
- Increase safe and meaningful community participation by building Mr. A's confidence, communication skills, and capacity to engage in interest-based community activities with structured and supported exposure.
- Build Mr. A's capacity in personal care, domestic tasks, and self-management through structured, scaffolded capacity-building interventions and consistent prompting systems.
- Support Mr. A's development of communication and social skills through structured opportunities for interaction, modelling, and reinforcement within home and community environments.
- For Mr. A to have a pool of direct support providers who are trained, consistent, and confident in implementing capacity-building strategies, communication approaches, and OT interventions to ensure continuity of care.
- To establish and maintain regular monthly Care Team Meetings (CTMs) to review Mr. A's progress, monitor support needs, ensure consistency of support strategies, and enable timely communication and collaboration between all stakeholders.

OT Funding Needs

To build Mr. A's functional capacity, the following OT funding is required for the next 12 months:

Distribution	Task	Clinical Reasoning	Funding Required
1st Quarter	Fortnightly direct OT sessions in Mr. A's usual environment	To work directly with Mr. A on his goals and to build his capacity.	12 hours
1st Quarter	Monthly care team meetings and collaborations with Mr. A's other capacity-building providers	To ensure services are provided in a collaborative manner.	3 hours
1st Quarter	Staff training, including prep	To ensure Mr. A's support workers are capable and proficient in providing support relating to his needs.	3 hours
2nd Quarter	Fortnightly direct OT sessions in Mr. A's usual environment	To work directly with Mr. A on his goals and to build his capacity.	12 hours
2nd Quarter	Monthly care team meetings	To ensure services are provided in a collaborative manner.	3 hours
2nd Quarter	Staff training, including prep	To ensure support workers are proficient.	3 hours
3rd Quarter	Fortnightly direct OT sessions in Mr. A's usual environment	To work directly with Mr. A on his goals and to build his capacity.	12 hours
3rd Quarter	Monthly care team meetings	To ensure collaborative service provision.	3 hours
3rd Quarter	Staff training, including prep	To ensure support workers are proficient.	3 hours
4th Quarter	Fortnightly direct OT sessions in Mr. A's usual environment	To work directly with Mr. A on his goals and to build his capacity.	12 hours
4th Quarter	Monthly care team meetings	To ensure collaborative service provision.	3 hours
4th Quarter	Re-assessment and progress report	To comply with the NDIS Act. To capture changes in Mr. A's functioning and incorporate relevant changes to the OT program.	8 hours
Total			77 hours

Risks if NDIS Funding for OT is not Provided

The writer has identified the following risks should the above-listed Occupational Therapy funding not, or only partly, be provided in Mr. A's NDIS plan:

- Breakdown of informal care arrangement: Without OT input to guide the transition into SIL and structured capacity-building, there is a high risk that the current informal care arrangement will break down in crisis, given the declining health of Mr. A's parents.
- Failure to develop independent living skills: Reduced OT input will limit Mr. A's ability to build capacity in essential daily living tasks (self-care, domestic tasks, community access),

resulting in lifelong dependence on high-cost supports without progression toward increased independence.

- Increased risk of behavioural deterioration: Without OT-led capacity building and consistent strategy implementation, Mr. A is at risk of increased emotional distress, reduced participation in daily activities, and behavioural escalation.
- Carer breakdown: Without appropriate formal supports and OT guidance, Mr. A's parents are at significant risk of complete burnout, resulting in unplanned crisis transition and significant distress for Mr. A.
- Reduced engagement with supports: Without consistent OT involvement, Mr. A may experience reduced engagement with capacity-building activities, leading to further decline in functional capacity over time.

Risks if Home and Living Supports are not Provided

If appropriate Home and Living supports, including SIL, are not provided, Mr. A is at significant risk of deterioration across multiple domains:

- Unplanned crisis transition due to parental incapacity, leading to acute distress and functional decline.
- Reduced engagement with services and capacity-building opportunities, leading to further decline in functional capacity.
- Increased risk of behavioural escalation due to absence of consistent structure and predictable supports.
- Significant carer fatigue and breakdown impacting Mr. A's parents' health.
- Neglect of self-care, health, and daily living needs, impacting Mr. A's physical and emotional wellbeing.
- Social isolation and reduced community participation, limiting quality of life and goal attainment.

Transition Planning

A structured and well-coordinated transition plan is essential to support Mr. A in moving into a SIL environment successfully.

Pre-Transition Phase

- Identify and match Mr. A with a suitable SIL provider and compatible living environment (considering peers, environment, and support model).
- Conduct meet-and-greet sessions with staff and potential housemates to build familiarity and reduce anxiety.
- Develop a comprehensive transition plan in collaboration with Mr. A, his parents, support coordinator, and OT.
- Establish clear communication strategies and capacity-building protocols.
- Prepare Mr. A through gradual exposure (e.g., short visits, day stays, overnight trials).
- Develop visual supports and routines to assist with understanding the transition.

Transition Phase (Move-In Period)

- Provide intensive 1:1 support during the initial transition period.
- Ensure familiar supports (e.g., known support workers where possible) are present to reduce distress.
- Gradually introduce routines and expectations within the new environment.
- Implement capacity-building strategies consistently from day one.
- Monitor closely for signs of distress, escalation, or withdrawal.
- Maintain frequent communication between all stakeholders (family, support coordinator, OT, SIL provider).

Post-Transition Phase (Stabilisation and Capacity Building)

- Continue consistent support with a focus on routine establishment and skill development.
- Gradually build independence in daily living tasks through structured capacity-building interventions.
- Support engagement in meaningful activities aligned with Mr. A’s interests (e.g., day program, walks, music).
- Ongoing review and adjustment of support strategies based on Mr. A’s progress and needs.
- Maintain involvement of Mr. A’s parents and family as part of his support network.
- Regular multidisciplinary team reviews to ensure consistency and effectiveness of supports.

SUMMARY

Mr. A is a 26-year-old man with a complex disability profile, including Autism Spectrum Disorder (ASD) Level 2 and Mild to Moderate Intellectual Disability. He has lived his entire life in the family home with his parents, who have been his primary informal carers. However, both parents are now managing significant health conditions that have substantially reduced their capacity to continue providing the level of support Mr. A requires.

Functionally, Mr. A presents with substantial support needs across all domains of daily living. He requires significant assistance with communication, social interaction, learning new skills, self-care, domestic tasks, community access, and financial management. While he is physically capable of many tasks, his cognitive functioning, executive functioning deficits, and capacity for independent decision-making significantly impact his ability to complete activities without intensive prompting, supervision, and support.

Mr. A demonstrates strengths in his warm and sociable disposition, his genuine desire for social connection, and his positive engagement when supported in structured, interest-based environments. He has expressed clear goals around developing his independence, building friendships, and participating in meaningful daily activities.

Mr. A currently requires a highly structured, consistent, and supervised support model with 24/7 oversight to ensure safety, support skill development, and facilitate engagement in meaningful activities. Ongoing capacity-building is essential in areas such as communication, daily living skills, social participation, and community engagement. Without this level of support, there is a high risk of crisis breakdown of the current informal care arrangement, with significant distress and functional decline for Mr. A.

A planned, supported, and gradual transition into a SIL arrangement is strongly recommended while his parents are still able to participate in the transition. This will provide Mr. A with a sustainable long-term living solution, address the urgent risk of carer breakdown, and support his progression toward his stated goals of greater independence and meaningful participation.

Support Requirements

For Mr. A to work towards his goals and aspirations, the following NDIS-funded supports are required:

Service	Clinical Reasoning	Funding Required
Supported Independent Living (SIL)	Mr. A requires substantial and consistent support across all domains of daily living due to the impact of his ASD Level 2 and Intellectual Disability. He requires continuous supervision and prompting to safely engage in personal care, domestic tasks, medication management, community access, and structured daily routines. Mr. A demonstrates significant vulnerability in unsupervised settings due to limited safety awareness and reduced insight. He requires structured, predictable support both during the day and overnight to maintain stability and support skill development.	1:3 shared support 12–14 hours per day (active support) | 1:1 community access support | Sleepover/inactive overnight support
Social and Community Participation	Mr. A requires significant support to safely and meaningfully engage in community participation. Structured, supported, and graded community access is essential to develop his social skills, reduce isolation, and support participation in interest-based activities. Community engagement must be facilitated through 1:1 support due to his vulnerability and need for individual supervision in community settings.	1:1 community access support, 4–6 hours per day, as per goals and routine structure
Funding for Transport	Mr. A is unable to independently access the community due to his disability profile, including limited road safety awareness, communication support needs, and vulnerability in unfamiliar environments. He requires supported transport to ensure safe attendance at appointments, day programs, and community activities.	Level 2 Transport Funding
Support Coordination	Mr. A presents with a complex support environment involving multiple intersecting providers and the urgent need to plan and implement a transition into SIL. Support Coordination is required to ensure system integration, support transition planning, coordinate communication between stakeholders, and ensure consistency of supports.	Support Coordination (Level 2)
Occupational Therapy	As elaborated above. To work directly with Mr. A on his goals, build his functional capacity, develop daily routines, support community participation, and provide consistent guidance to his support team.	77 hours per year
Day Program / Group-Based Activity	Mr. A has expressed a clear interest in attending a structured day program or activity group to expand his social connections and engagement in meaningful activities. A day program will provide structured engagement, social interaction with peers, and opportunities for skill development in a supported environment.	4–5 days per week of day program attendance

OTHER RECOMMENDATIONS

Non-NDIS Funded Support:

- Ongoing GP management to monitor Mr. A's general health and wellbeing.
- Regular dental review, particularly given Mr. A's reduced capacity to consistently maintain oral hygiene independently.
- Consideration of guardianship and financial administration applications through VCAT to formalise decision-making support given Mr. A's reduced capacity in these domains and his parents' declining capacity to provide informal decision-making support.

– End of report –

It was a pleasure to meet Mr. A.

Please don't hesitate to contact me should you have any queries.

[OT Name]

Occupational Therapist