How to Apply for NDIS | Step-by-Step Guide | Bloom Healthcare

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Details:

There are four stages, and most families get stuck between two of them. You establish eligibility and make an access request with evidence. You attend a planning meeting and receive a plan with budgets. You choose how the plan is managed, choose providers and sign service agreements. Then you use the plan, gather evidence of what changed, and take that to reassessment. The NDIA contact line for every stage is 1800 800 110 . This page walks the whole sequence, including the parts that are usually skipped: what a service agreement must contain, what your rights are when a provider is not working out, and what to do when a decision goes against you.

Stage 1: Eligibility

Three tests, all of which have to be met.

Age. You must be under 65 when you apply.

Residency. Australian citizen, permanent resident, or holder of a Protected Special Category Visa.

Disability or developmental delay. The disability must be permanent, meaning lifelong, and significantly affect the ability to take part in everyday activities. For young children, developmental delay requiring early intervention can qualify.

The test the NDIA applies is functional, not diagnostic. Two people with the same diagnosis can get very different answers, because what matters is how the condition affects daily life. This is why the evidence you provide has to describe function, not just name a condition.

For children under seven, a formal diagnosis is not required to access support. Diagnosis at that age can take time and observation, and the scheme does not make families wait for it.

Stage 2: Evidence, gathered before you apply

This is the stage that most affects the outcome, and it is the one people rush. The NDIA needs documentation that establishes the nature of the disability, how it functionally affects daily activities and participation, that it is permanent or will need ongoing support, and why support is needed for independence and community participation.

What to collect:

Medical documentation. Diagnostic reports from specialists, letters from your GP or consultants explaining the disability and its functional impact, recent assessments.

Therapy assessments. Speech pathology, occupational therapy, physiotherapy, psychology or behavioural assessments.

A functional capacity assessment. This describes how the disability affects daily function across the key life domains and is the most directly useful document in an access request.

Educational records for children. School reports, teacher feedback on learning and participation, developmental milestone documentation.

Aim for evidence that says what the person cannot do without help, how often, and what happens when help is not there. Vague letters produce vague decisions.

Stage 3: The access request

Contact the NDIA on 1800 800 110 or through the NDIS website and ask for an Access Request Form. Families with young children can also go through an Early Childhood Partner instead.

Complete the form thoroughly and submit it with your supporting documents. The NDIA may come back asking for more information, or arrange an assessment.

A GP, specialist, allied health clinician, Local Area Coordinator or Early Childhood Partner can all help you put this together. Bloom offers an access readiness package that includes consultation and a functional capacity assessment to prepare the evidence for an application. Call 1300 771 465 .

Stage 4: The decision

The NDIA reviews the application and notifies you of the outcome. If access is granted, the next step is a planning meeting to build the plan. If it is refused, go to Stage 12 on this page rather than starting again from scratch.

Stage 5: The planning meeting

You meet an NDIA planner or a Local Area Coordinator to build the plan. This is where your goals become the structure the funding hangs off, so it is worth preparing properly.

Bring:

Clear goals. What the person wants to achieve. Improving mobility, learning new skills, taking part in community activities, working, studying, living more independently.

A list of current supports. Both formal, such as therapies, and informal, such as what family members do.

The challenges. Where extra support is needed: communication, self-care, transport, mealtimes, behaviour, safety.

The evidence. Assessments and medical reports.

Questions about support coordination. Not every plan includes funding for a support coordinator or plan manager, so raise it in the meeting if you want it.

The planner works with you to identify supports that are reasonable and necessary, allocate funding across the budget categories, and agree the type and frequency of services.

Stage 6: Reading the plan you receive

Every plan is built from three budget types, and knowing which is which prevents a lot of wasted time.

Core Supports. The most flexible budget. It funds everyday assistance: personal care, domestic help, transport, meal preparation and eating assistance, social and recreational participation, and consumables. Funding here can generally be moved between the supports inside it.

Capital Supports. Assistive technology and home modifications. Wheelchairs, communication devices, hearing aids, ramps, bathroom alterations, vehicle modifications. Capital funding is tied to the specific item and requires approval based on detailed recommendations from an allied health professional, usually an occupational therapist. You cannot spend it on something else.

Capacity Building Supports. Skill development and independence. This is where therapy sits, including occupational therapy, speech pathology, physiotherapy, exercise physiology, psychology, dietetics and positive behaviour support, along with employment supports and social participation programs. It is divided into sub-categories, the most common being Improved Daily Living and Improved Health and Wellbeing.

Some supports are described in a plan as stated supports , meaning the funding is locked to that specific purpose and cannot be redirected. Check your plan wording, because it changes what you can do with the money.

The boundary between Core and Capacity Building matters in practice. If someone else needs to do the task for you, that is usually Core. If a clinician is building a skill, prescribing a strategy or writing evidence, that is usually Capacity Building.

Stage 7: Choosing how the plan is managed

Three options, and you can hold different arrangements for different parts of a plan.

Self-managed. You handle payments, budgeting and record keeping. Most flexibility, most administration, and you can use unregistered providers.

Plan-managed. A registered plan manager handles the financial administration, paying invoices and tracking budgets. You can still use unregistered providers.

NDIA-managed. The NDIA pays providers directly. You must use NDIS registered providers.

Only participants who self-manage or plan-manage can choose unregistered providers. That single rule determines the size of your provider list.

Stage 8: Choosing providers

The NDIS Provider Register, maintained by the NDIS Commission, is the public directory of registered providers, including their registration certificates and any conditions on their registration. Start there if you need a registered provider.

Registration is mandatory for providers who deliver specialist disability accommodation, specialist behaviour support, supported independent living, plan management, NDIS digital platform services, supports to NDIA-managed participants, or who use regulated restrictive practices. Registered providers are audited against the NDIS Practice Standards, assessed for suitability along with their key personnel, and issued a certificate valid for three years.

Beyond registration, ask about experience with the specific need, the delivery options available, geographic coverage, and how the provider handles complaints and incidents. Sensible questions include their registration status and number, how their pricing aligns with NDIS Pricing Arrangements, what the cancellation and travel arrangements are, whether they deliver in-home, in community, in clinic or by telehealth, how they manage complaints, and whether materials are available in easy read.

Stage 9: The service agreement

A service agreement is a written contract between you and the provider. It must be completed, documented and signed by both parties before services and billing start. Read it before you sign.

It should set out:

the specific supports to be provided and the conditions attached to them

the hours authorised and allocated

rates and travel costs in line with the NDIS Pricing Arrangements and Price Limits, and confirmation the funding exists in your plan

reporting requirements and expected hours

cancellation arrangements and how the provider will communicate with you

emergency contacts, privacy and confidentiality information, and your consent to information being collected and used under the Privacy Act 1988

your rights and obligations, in easy read format if that helps

You must agree to any proposed change to a service agreement before it takes effect. A provider cannot change pricing, hours or terms without your consent, and you can refuse.

Stage 10: Using the plan

The myplace participant portal, reached through myGov, lets you view your plan, track spending against your budgets and manage service bookings. The NDIA publishes guidance for families new to it.

Practical habits that make a plan last the year: check the budget monthly rather than at the end, keep invoices and reports in one place, and ask providers early what proportion of your budget their proposed schedule will use. Reporting time comes out of your therapy budgets too, so include it in the maths.

Stage 11: Collecting evidence as you go

The evidence for your next plan is built during this one. Ask each provider what they will produce and when. Useful documentation includes progress summaries tied to your goals, baseline measures with progress against them, what was tried and what worked, and any risks or unmet needs.

The NDIA expects a report for plan reassessment to explain the therapy approach and give evidence of outcomes achieved and progress made toward goals. A report that does not do those two things will not carry a funding request.

Stage 12: Reassessment and change of circumstances

Plans are reviewed annually, with progress summaries and reports assessed against your goals to decide what supports remain reasonable and necessary.

You do not have to wait for the annual cycle. A change of circumstances review can be requested at any time by you, your family or an advocate. Reasons include a medical event or injury, a documented decline or improvement in capacity, a change in living arrangements, a shift in support needs or goals, or a significant life transition. Support the request with updated assessments.

Stage 13: If you disagree with a decision

First step is an internal review by the NDIA, which reconsiders the decision about access, funding or plan content. Put your reasons in writing and attach evidence, especially an updated functional capacity assessment.

If the internal review outcome is still wrong, there is an external merits review pathway, and a 28-day window from the internal review decision applies. The tribunal that hears these matters has been renamed since some guidance was written, so confirm the current tribunal name, the exact deadline and the lodgement process with the NDIA on 1800 800 110 or with a disability advocate before you

lodge. Missing the window can cost you the right of appeal.

Free disability advocacy services exist for exactly this situation. You are not expected to do it alone.

Your rights, and complaints

You have the right to choose your provider, and the right to change provider. If you or the provider ends the arrangement, the provider must work with you so you can keep accessing supports until services end, and must notify the NDIS Commission of the change.

If something goes wrong, registered providers are required to have a documented complaints system that is accessible, allows anonymous complaints, keeps you informed of decisions and actions, has a separate path for complaints about leadership, and refers matters onward where a criminal offence may have occurred. You can complain to the provider or directly to the NDIS Commission , which can raise the matter with the provider on your behalf.

Providers must handle complaints with procedural fairness: a real opportunity to be heard, decisions based on the facts, and impartiality. Threatening someone or trying to stop them complaining is against the law and carries penalties.

Children: which system applies

The NDIS early childhood approach supports children aged 0 to 9 with developmental delay or disability. The upper age limit was extended from 7 to 9 from 1 July 2023, phased in progressively over the following two years. Children under 6 with developmental delay can access support without a formal diagnosis, and children aged 6 to 9 with an identified disability are also covered. It funds occupational therapy, speech pathology, physiotherapy, psychology and positive behaviour support, and for younger children it commonly runs through a key worker model with one coordinating clinician. Early Childhood Partners are local NDIS-funded organisations that help families understand the plan wording, make sure key worker services are included, guide the application, and connect families to services.

Thriving Kids is a separate Australian Government initiative for children aged 0 to 8 with developmental delay or autism and low to moderate support needs. It delivers early identification, information and advice, family and parenting support, time-limited targeted allied health, assistance with assistive technology, and workforce capability building. State-based services begin rolling out from 1 October 2026 , with full implementation from 1 January 2028 , at which point NDIS access arrangements change so that children aged 8 and under with developmental delay or autism and low to moderate support needs are directed to Thriving Kids instead. The NDIS continues to support children with permanent and significant disability and high support needs. Children who entered the NDIS before 1 January 2028 with low to moderate support needs are intended to be reassessed under the criteria that applied before that date.

The two systems have different eligibility and different rules. Do not assume an NDIS rule applies to Thriving Kids. Bloom has detail in Thriving Kids eligibility and in Thriving Kids compared with the NDIS for children under 8 .

Where Bloom fits

Bloom Healthcare is an NDIS registered provider delivering allied health, including occupational therapy , speech pathology , physiotherapy, dietetics, psychology and positive behaviour support, to NDIA-managed, plan-managed and self-managed participants. Services are delivered in the home, in the community, at school, by telehealth and in clinic where appropriate, across New South Wales, Queensland, Victoria, South Australia, Tasmania, Western Australia and the Australian Capital Territory.

The practical help most families need is at two points: preparing evidence before an access request or planning meeting, and producing reports that hold up at reassessment.

Phone 1300 771 465

Make a referral

Common questions about applying for and using an NDIS plan

How long does an access decision take?

We cannot give a reliable timeframe, and it varies with the completeness of your application. The most useful thing you can control is the quality of the evidence you submit up front, because incomplete applications generate requests for more information and that adds time. Ask the NDIA on 1800 800 110 for current timeframes.

Do I need a diagnosis to apply?

Not always. Eligibility turns on the functional impact of a permanent disability rather than the diagnosis alone, and for children under seven a formal diagnosis is not required. You still need evidence describing the impact.

What is the single most useful document in an application?

Usually a functional capacity assessment, because it describes how the disability affects daily function across the domains the NDIA cares about. Medical letters establish the condition; the functional assessment establishes the need.

What is the difference between Core, Capital and Capacity Building?

Core pays for everyday assistance and is the most flexible. Capital pays for equipment and home modifications and is tied to the approved item. Capacity Building pays for therapy and skill development. Some supports are stated, meaning the funding cannot be moved.

Can I use an unregistered provider?

Only if you self-manage or plan-manage. NDIA-managed participants must use registered providers. Registration is also mandatory for certain support types regardless of how you manage your plan, including specialist behaviour support, supported independent living and specialist disability accommodation.

Do I have to sign a service agreement?

Yes. It must be completed, documented and signed by both you and the provider before services start and before any billing. Read the pricing, cancellation and travel terms before you sign, and ask for an easy read version if that helps.

Can a provider change my rates or hours partway through?

Not without your agreement. You must agree to proposed changes to a service agreement before they are implemented, and you can say no.

How do I change providers?

You have the right to choose and to change. The provider must work with you so you can keep accessing supports until services end, and must notify the NDIS Commission of the change. Line up the new provider before you end with the old one where you can, so there is no gap.

What if I am unhappy with the quality or safety of a support?

Complain to the provider through their complaints system, which must be accessible and can accept anonymous complaints, or go directly to the NDIS Commission. The Commission can support you to raise it with the provider or speak to the provider itself.

My plan does not have enough funding. What can I do?

Request an internal review by the NDIA and support it with evidence, particularly an updated functional capacity assessment and provider reports that show functional impact and unmet need. If the internal review does not resolve it, there is an external review pathway with a 28-day window from the internal review decision. Confirm the current tribunal and process on 1800 800 110.

Can I get a plan changed before the annual review?

Yes. A change of circumstances review can be requested at any time by you, your family or an advocate, backed by evidence. Common triggers are a medical event, a change in capacity, a change in living arrangements, or new goals.

My child is under 8. Should I be looking at the NDIS or Thriving Kids?

It depends on support needs and on timing. The NDIS continues to support children with permanent and significant disability and high support needs. Thriving Kids is for children aged 0 to 8 with developmental delay or autism and low to moderate support needs, rolling out from 1 October 2026 with full implementation from 1 January 2028. Check both against your child's situation rather than assuming, and speak to an Early Childhood Partner.

I am 64 and about to turn 65. Does that matter?

Yes. The age test applies at the time you apply, so applying before turning 65 matters. If you are already over 65, the aged care system is the pathway rather than the NDIS, and its rules are different. My Aged Care is the starting point.

What is the NDIS and what is its purpose?

The National Disability Insurance Scheme (NDIS) is an Australian government initiative designed to empower individuals with disabilities to achieve their goals, participate in the community, and improve their quality of life. It provides funding for reasonable and necessary support to people with permanent and significant disabilities.

What are the key principles of the NDIS?

The NDIS is built on three key principles: Individualised Support, where participants' plans are tailored to their unique needs and goals; Choice and Control, where participants can choose how their funding is used and which providers they work with; and Capacity Building, which focuses on building skills and independence to improve long-term outcomes.

Which agency administers the NDIS?

The NDIS is administered by the National Disability Insurance Agency (NDIA), which oversees eligibility, planning, and funding processes.

What are the eligibility criteria to qualify for the NDIS?

To qualify for the NDIS, applicants must be under 65 years old when applying; be an Australian citizen or permanent resident, or hold a Protected Special Category Visa; and have a disability that is permanent (lifelong) and significantly impacts their ability to participate in everyday activities. For children under six, developmental delays that require early intervention may also qualify.

Does NDIS eligibility depend on a specific diagnosis?

No. Eligibility focuses on the functional impact of the disability rather than the diagnosis alone. For example, two people with the same diagnosis may have vastly different support needs depending on how the condition affects their daily lives.

What topics does this NDIS guide for families cover?

The guide walks families through NDIS eligibility, gathering evidence, making an access request, the planning meeting, plan budgets, service agreements, and reviews and appeals.

What kind of organisation is Bloom Healthcare?

Bloom Healthcare is a boutique disability and aged care allied health provider that aims to change the status quo, believing all people have the right to access quality healthcare. Its healthcare model focuses on evidence-based practice and client centricity, delivered by highly qualified health practitioners across Australia.

How can Bloom Healthcare be contacted?

Bloom Healthcare can be contacted by email at hello@bloom-healthcare.com.au or by phone at 1300 771 465.