manawanui | YOUR CHOICE, MADE EASY
Kei ia koe ano to Rangatiratanga

Pre-Approval Form

Please ensure you complete the first two sections, along with further details in the relevant section and return to CEC@manawanui.org.nz.

By filling out and submitting this form you acknowledge that:

- **You have read and considered the information at the top of this document**
- **You have completed the first two required sections and the relevant details section related to the reason for your pre-approval**
- **This pre-approval is only valid for three months from the application date and is dependent on you having sufficient funding to cover the pre-approval when it is claimed**
- **The pre-approval form does not guarantee that the purchase will be approved**
- **The pre-approval cover pre-approvals for your current funding(s) ONLY**
- **We may share this information with your NASC**

When completing this form, consider the below questions:

1. Is the purchase related to a **specific purpose(s) agreed in your My DSS Funding Plan**, or in your Individual Service Plan?
2. Is the **purchase necessary due to the person's disability**?
    a. What opportunities is this creating that wouldn't be needed if the person wasn't disabled?
    b. What **barriers does this purchase overcome** for the person?
    c. How does this purchase **promote independence / skill development**?
    d. Are there **other supports** (non DSS) that might be able to address this need?
3. Considerations as part of budget management
    a. Will making this purchase **compromise access to other necessary supports** through to the end of the funding period?
    b. Does it **reduce the need for further support** e.g. reduce support worker hours?
    c. Is this purchase **solely related to disability**, or would a personal contribution be appropriate?
    d. What impact will the purchase have on the allocated budget?
    e. Is there a **contingency plan** in place to cover any additional supports required during their allocation period?
4. Are there any **other sources of funding available** and have they been considered?
    a. The availability of funding from other agencies does not preclude the use of DSS funding to purchase an item or support. However, it is expected that services available from other government agencies have been explored before supports of similar form or intent are included in a plan.

General Information* **Required**	
Application Date:	
Funded Person:	
Agent Name (if applicable):	
Estimated date of purchase:	
Funding to be used: (e.g.MoH IF, MoH IF Respite, EIF)	

Pre-Approval Information* **Required**		
Item Description	**Item Cost** $	**Personal Contribution** (if any) $
Reason for Pre-Approval		
Is the purchase related to specific parts of the purpose(s) agreed in the My DSS Funding Plan or ISP? If so, which part?		
Please detail how this purchase helps the client address a barrier to disability.		
Does making this purchase compromise your remaining budget?		
What contingency plan(s) do you have in place if answered **yes** above?		
Are there any other sources of funding available and have they been considered? If so, have you been declined or on the waiting list, please provide evidence to support this?		
Any other information we should be aware of?		

Please only complete the section below that relates to the **Reason for Pre-Approval** you have selected above.

Overseas Travel Details	
Travelling Party (incl. Support Worker)Names:	
Travel Dates:	
Total number of days overseas:	
Destination(s):	

Reason for Travel:	
Description of travel costs to be claimed from (each) funding:	

Equipment Details

Does the equipment have the potential to pose a risk of harm?	
If yes, has a health professional operating within the scope of their practice confirmed that it is safe?	
Please detail how this equipment will help support the clients independence or provide safety.	

If you have answered yes to the first two questions in this section, please ensure that you attach evidence from your registered health professional.

Complementary Therapies Details

This comprises health care and/or medical practices that are used alongside conventional medical treatments.

Description of the complementary therapy	
Has the therapy been recommended by a registered health professional operating within the scope of their practice?	
How many sessions are you seeking pre-approval for?	

If you have answered yes to the first two questions in this section, please ensure that you attach evidence from your registered health professional.

Repeat Purchases Details

Date previous similar purchase was made:	
Reason for repeat purchase?	
If the reason was due to theft or damage, was this covered under your contents insurance?	

Purchases Over Tier Limit Details

Tier Level	

Has funding from other agencies or government organisations been explored?	
Will the purchase reduce support worker hours? Or does it assist in overcoming certain barriers?	