

Program setup form

For assistance with the form please email helpdesk@rhealth.com.au.

PHN:	DDWMPHN
Program name:	
Program details/description: Referenced from PHN websites	
Eligibility: E.g., age, postcode	
Referral pathways: E.g., GP only, self-referral allowed	
Program type: E.g., Allied Health, Mental Health, Care Coordination	
Number of sessions allowed on referral: The number of sessions that a person can access on a single referral	Initial sessions: Sessions after review: Maximum per referral: Maximum per financial year: <i>If there is no limit, write 'no limit' next to 'Maximum per referral'.</i>
Data collection requirements (other): If additional data needs to be collected in addition to the PMHC-MDS	

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Program contact/s: Name, phone, and email	
Provider/s: Provider organisations, include name, address, and contact details	
<u>Provider 1</u>	<u>Provider 2</u>
Name:	Name:
Address:	Address:
Phone:	Phone:
Email:	Email:
ABN (for MDS purposes):	ABN (for MDS purposes):
Contact person:	Contact person:
Training and onboarding required: Is training required for referrals and/or providers?	
Referral expiry requirements (optional) e.g. Auto expiry if no sessions after a time period	
Auto-decline requirements (optional) e.g. Auto decline and notify referrer if no action within a certain timeframe	
Additional consent requirements Leave blank for standard PMHC MDS Consent protocol	
Contractual Data Entry Targets Cut-off for regular data to be in the system. (e.g. within 3 days of end of month)	
Additional features related to program Does this program require budgets/invoicing modules, surveys, anything not covered above?	

Completed by:	
PHN representative/s involved:	
Date completed:	