

## Know Your Options – New Service Provider Application Form

This application form is to have your service listed on the Know Your Options website. Your application will be considered by SA Health and we will get back to you within 28 days of applying to be listed. **Please ensure all fields are complete, incomplete applications will be returned.**

| SERVICE DETAILS   |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
|---|-----------------------------------|----------------------|-------------------------|----------------------|---------------------|---------------------------------------|-------------------|----------------|---------------------------------------|---------------|----------------------|--------------------------------|-----------------------------------|--|----------------------------|--|--|-----------------------|--|--|
| Organisation/Service Name:  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Program:  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Service Address:  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| <p>Service Type: Please tick all boxes that apply</p> <table border="0"> <tr> <td>Assessment and Referral</td> <td>Sobering Up Services</td> <td>Aboriginal Services</td> </tr> <tr> <td>Counselling</td> <td>Outreach Services</td> <td>Youth Services</td> </tr> <tr> <td>Medication Assisted Treatment (MATOD)</td> <td>Mental Health</td> <td>Clean Needle Program</td> </tr> <tr> <td>Non-residential Rehabilitation</td> <td>Family, Peer and Support Services</td> <td></td> </tr> <tr> <td>Residential Rehabilitation</td> <td></td> <td></td> </tr> <tr> <td>Withdrawal Management</td> <td></td> <td></td> </tr> </table> |                                   |                      | Assessment and Referral | Sobering Up Services | Aboriginal Services | Counselling                           | Outreach Services | Youth Services | Medication Assisted Treatment (MATOD) | Mental Health | Clean Needle Program | Non-residential Rehabilitation | Family, Peer and Support Services |  | Residential Rehabilitation |  |  | Withdrawal Management |  |  |
| Assessment and Referral   | Sobering Up Services              | Aboriginal Services  |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Counselling   | Outreach Services                 | Youth Services       |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Medication Assisted Treatment (MATOD)   | Mental Health                     | Clean Needle Program |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Non-residential Rehabilitation  | Family, Peer and Support Services |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Residential Rehabilitation  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Withdrawal Management   |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| <p>Target Population: Please tick all boxes that apply</p> <table border="0"> <tr> <td>Aboriginal</td> <td>Family and Friends</td> <td>Women</td> </tr> <tr> <td>Culturally and Linguistically Diverse</td> <td>Under 25</td> <td>LGBTI</td> </tr> </table>   |                                   |                      | Aboriginal              | Family and Friends   | Women               | Culturally and Linguistically Diverse | Under 25          | LGBTI          |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Aboriginal  | Family and Friends                | Women                |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Culturally and Linguistically Diverse   | Under 25                          | LGBTI                |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Other (please specify):   |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Service Description:  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Statewide Service:  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
| Opening Times & Hours:  |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |
|   |                                   |                      |                         |                      |                     |                                       |                   |                |                                       |               |                      |                                |                                   |  |                            |  |  |                       |  |  |

Referral Required:

Service Cost:

**SERVICE CONTACT DETAILS**

Contact Name:

Phone Number:

Mobile:

Fax:

Website:

Email:

Facebook:

**SERVICE ACCREDITATION**

Does this Service have Quality Accreditation: (e.g. ISO 9001:2000, QIC, QIP, ASES)

*\*Please attach evidence of accreditation with expiry date (e.g. certificate)*

Quality Accredited by:

Quality Accreditation expiry date:

**PROFESSIONAL REGISTRATION (Applies to individuals/health professionals)**

Is this Service/Provider registered with a professional body (e.g. AHPRA)?

Registration details:

**SERVICE FEEDBACK/COMPLAINTS**

Please provide information about your complaints policy/process and where to direct feedback received by DASSA:

Are you willing to respond/provide outcomes to DASSA regarding any feedback we forward through?

**SERVICE FUNDING**

What is the main funding source for the service? (e.g. Commonwealth or SA Health funded)

Please return your completed form to:

**Alcohol and Drug Information Service (ADIS)**

**Phone: 1300 131 340 (8:30AM – 10:00PM)**

**[HealthDASSAADIS@sa.gov.au](mailto:HealthDASSAADIS@sa.gov.au)**