

# Applicant Information Sheet for MASS CFP10 Cystic Fibrosis Program Application



Applicants should retain this section for their records

## Eligibility

Administrative eligibility is dependent upon the applicant being a permanent Queensland resident. The applicant must hold one of the following eligibility cards – in the name of the applicant:

- Centrelink Pensioner Concession Card
- Centrelink Health Care Card
- Centrelink Confirmation of Concession Card Entitlement Form (conditions apply)
- Department of Veterans' Affairs (DVA) Pensioner Concession Card (conditions apply)
- Queensland Government Seniors Card

Please provide a **copy of both sides of the eligibility card**, OR **signed consent to access Centrelink information** on the MASS 84 Proxy Access to Centrelink Information Form.

Clinical eligibility will be determined by the Cystic Fibrosis Program (CFP) based on information provided by the CFP designated prescriber as detailed in the CFP administrative guidelines.

CFP aids and equipment are not provided by the program for hospital inpatients and high care residents of Commonwealth funded care facilities.

## How to Apply

The CFP operates through a prescriber model in that CFP designated prescribers, in consultation with the applicant submit an application (on behalf of the applicant) to the CFP for consideration for aids and equipment assistance.

The CFP designated prescriber completes the application form in accordance with the CFP administrative guidelines. Website: [www.health.qld.gov.au/mass](http://www.health.qld.gov.au/mass)

The CFP designated aids and equipment prescribers are:

- Physiotherapists associated with a cystic fibrosis centre or clinic
- Registered nurses associated with a cystic fibrosis centre or clinic (for nebulisers only).

## Post or Fax Completed Forms to

Cystic Fibrosis Program  
Medical Aids Subsidy Scheme  
41 Southgate Avenue Cannon Hill QLD 4170  
PO Box 281 Cannon Hill QLD 4170  
Telephone: 3136 3510  
Fax: 3136 3500  
Email: [cfp184@health.qld.gov.au](mailto:cfp184@health.qld.gov.au) (email for Queensland Health hospitals only)

## Prescriber Information for the Applicant


## Applicant Acknowledgement

- I confirm that:**
- 1** I have actively participated in the assessment and trialling of the aid(s) and associated modifications and / or accessories
  - 2** the features and options of the aid(s), and any appropriate alternatives have been fully explained to me by my prescribing health professional
  - 3** the possible cost implications that I may incur as a result of CFP administrative guidelines have been explained to me by my prescribing health professional
  - 4** the aid(s) prescribed are suitable for my needs
  - 5** I have a safety switch (residual current device) installed in my home and am using a surge protection device (only applicable for aids that require charging / operation through mains power).

- 
- I acknowledge that:**
- 6** the aid(s) provided by the CFP are owned by me and that repairs and maintenance become my responsibility
  - 7** the CFP takes no responsibility for any injury sustained by me when using the aid(s)
  - 8** the aid(s) will only be used by me and for the purposes prescribed
  - 9** unless the aid(s) is supplied to me with a written notice confirming that it has been tested for electrical safety and that the aid(s) was found to be electrically safe, I should assume that it has not been tested and where the assumption applies, Queensland Health makes no warranty as to the electrical safety of the equipment (only applicable for aids that require charging / operation through mains power).

- 
- I agree to:**
- 10** answer promptly any enquiries made from time to time by the CFP
  - 11** notify my health professional prescriber should I cease to be able to use the aid(s) safely and effectively
  - 12** inform the CFP within 14 days of any change in my residential address, or eligibility for assistance e.g. no longer eligible for a health care card.

## MASS Privacy Statement

**YOUR PRIVACY:** The Queensland Health, *Medical Aids Subsidy Scheme (MASS)* is collecting administrative, demographic and clinical data as part of the MASS application processes, in accordance with the *Information Privacy Act 2009 and Health Services Act 1991*, in order to assess the applicant's eligibility for funding assistance for the supply of aids and equipment.

The information will only be accessed by Queensland Health officers. Some of this information may be given to the applicant's carer or guardian; other government departments who provide associated services; the prescribing health professional for further clinical management purposes; and to those parties (e.g. commercial suppliers and repairers) requiring the information for the purpose of providing aids, equipment and services.

Your information will not be given to any other person or organisation except where required by law.

For more information on the Queensland Health Privacy Policy, visit the website at:  
[www.health.qld.gov.au/privacy/1S42A.asp](http://www.health.qld.gov.au/privacy/1S42A.asp)



**Queensland**  
Government

Medical Aids Subsidy Scheme  
(MASS) Queensland Health

(Affix identification label here if available)

# MASS CFP10 Cystic Fibrosis Program Application

This form is used for all cystic fibrosis program applications and must be forwarded to the program for all aids and equipment

Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

## PART A To be completed by the applicant / carer

### Applicant's Personal Details

**1 Name**

Title	Family name	Given name(s)	Preferred name <input type="checkbox"/> First name <i>or specify</i>
-------	-------------	---------------	--

**2 Date of birth**      **Sex**  
 /  /        Male  Female

**3 Permanent residential address**

		Suburb / town	Postcode
Telephone	Fax	Mobile	Email

**4 Delivery address**  Same as residential address

		Suburb / town	Postcode
--	--	---------------	----------

**5 Postal address** (for correspondence)  Same as delivery address

		Suburb / town	Postcode
--	--	---------------	----------

**6 Is the applicant a resident in a Commonwealth funded care facility?**  Yes  No If yes, level  High  Low

Facility name
---------------

**7 Is the applicant of Aboriginal or Torres Strait Islander origin?** For applicants of both Aboriginal and Torres Strait Islander origin, tick both 'Yes' boxes. Aboriginal  Yes  No Torres Strait Islander  Yes  No

**8 Country of birth**  Australia Other       **Language spoken at home**  English Other

### Carer Information

**10 Name**

Title	Family name	Given name(s)
-------	-------------	---------------

**11 Contact information**

Telephone	Fax	Mobile	Email
-----------	-----	--------	-------

**12 Relationship to applicant**

**13 Postal address**

		Suburb / town	Postcode
--	--	---------------	----------

### Alternate Contact Person

I consent to the CFP, Queensland Health approaching my personal contact should the need arise. The name and address of one (1) personal contact who is aware that their name has been provided to CFP, **who does not reside with the applicant** and who will always be aware of the applicant's address is:

**14 Name in full**      **Relationship to applicant**

<input type="text"/>	<input type="text"/>
----------------------	----------------------

**15 Residential address**

		Suburb / town	Postcode
--	--	---------------	----------

**16 Contact information**

Telephone	Fax	Mobile	Email
-----------	-----	--------	-------

### Service Improvement Activities

**17** Your consent to service improvement activities means that you will be giving the CFP your permission to access your health information to improve the care the CFP and MASS provide to all its clients. These activities will allow the program to determine if the service is meeting people's needs and the service is complying with standards of practice.

**I agree to participate in CFP service improvement activities (including internal audits and surveys).**  Yes  No

At any time I can withdraw my agreement by contacting the MASS Quality Systems Coordinator on 3136 3614. I understand that there will be no effect to service provision by the CFP if I withdraw my consent.

**18**  I agree to accept the conditions stated in the *Applicant Information Sheet*.



# MASS CFP10 Cystic Fibrosis Program Application

Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

## PART B To be completed by the prescriber

### Aid(s) Prescribed and Eligibility

The aid(s) listed below has been trialled by the applicant and is suitable for the applicant.

- 1 The applicant has cystic fibrosis?  Yes  No      Has the aid been issued?  Yes  No
- 2 Nebulisers  LC Sprint  LC Plus      Nebuliser Masks  Mask  Child - size
- 3 Positive Expiratory Pressure (PEP) Systems  Sys 1  PEP S  PEP Pressure Gauge  Gauge / Port Indicator
- 4 Oscillating PEP devices  Ball driven  Magnet driven
- 5 Other Mucus Clearance Devices
- | Last date of application(s) | Last aid(s)          | Brand(s)             |
|-----------------------------|----------------------|----------------------|
| <input type="text"/>        | <input type="text"/> | <input type="text"/> |
- 6 Clinical justification  Delivery of inhaled medication  Airway clearance
- 7 Which Cystic Fibrosis Centre / Hospital is the applicant attending?

### Prescriber Details To be completed in full for all applications

- 9 Name  
Family name  Given name(s)
- 10  Respiratory Physiotherapist OR  Registered Nurse Registration current:  Yes  No
- 11 Facility  Department
- 12 Contact details
- | Telephone            | Fax                  | Mobile               | Email                | Suburb / town        | Postcode             |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
- 13 Signature  
I certify that the information contained in this application is in accordance with the CFP Administrative Guidelines.  Date

### Applicant Acknowledgement

16 I agree to accept the conditions stated in Part A of this application. I acknowledge that all my information listed in this application is current and correct.

Applicant / Carer signature  Print name  Date

NB If the applicant is located in a rural or remote area the designated prescriber(s) may sign below as a proxy, with consent, on behalf of the applicant.

Prescriber signature  Print name  Date

### Application Requirements MASS designated prescriber to complete

If all the requirements of the application form, as listed below, are not completed and signed this application will **not** proceed further, and the prescriber and the applicant will be advised.

- Application Information Sheet is retained by the applicant
- Attach a photocopy (front and back) of the applicant's current eligibility card / form OR signed MASS 84 Proxy Access to Centrelink Information Form
- Applicant Acknowledgement has been signed by the applicant
- A copy of the application has been retained by the prescriber

Please post or fax completed applications to  
Cystic Fibrosis Program

Medical Aids Subsidy Scheme  
PO Box 281 Cannon Hill QLD 4170 | Telephone: 07 3136 3510 | Fax: 07 3136 3500 | Email: cfp184@health.qld.gov.au  
(email for Queensland Health hospitals only)