



Medical Aids Subsidy Scheme, Queensland Health

**Mobility and Daily Living Aids  
Application Form**

(This form is used for mobility aids and daily living aids applications)

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

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 Medical Aids Subsidy Scheme (MASS) Clinical Advisor based on information provided by the MASS designated prescriber as detailed in the MASS Statewide Prescriber Procedures Manual.

Mobility and Daily Living Aids are not provided by MASS for hospital inpatients and high care residents of Commonwealth funded care facilities.

**How to Apply**

MASS operates through a prescriber model in that MASS designated prescribers, in consultation with the applicant, submit an application (on behalf of the applicant) to MASS for consideration for subsidy funding assistance.

The MASS designated prescriber completes the application form in accordance with the General and Mobility or Daily Living Aids sections of the MASS Statewide Prescriber Procedures Manual.

MASS designated mobility and daily living aids prescribers are:

- Physiotherapist (PT) - Occupational Therapist (OT) - Rehabilitation Engineer (Mobility Aids only)
- Registered Nurse (for rural/remote areas only, and in conjunction with a PT or OT)

**Post OR Fax completed forms to a MASS Service Centre**

***Brisbane:***

Medical Aids Subsidy Scheme  
PO Box 281 Cannon Hill Qld 4170  
Telephone: 3136 3524 Fax: 3136 3525  
Email: mass184@health.qld.gov.au  
Website: www.health.qld.gov.au/mass

***Townsville:***

Medical Aids Subsidy Scheme  
PO Box 980 Hyde Park Qld 4812  
Telephone: 4775 8000 Fax: 4775 8001  
Email: mass184@health.qld.gov.au  
Website: www.health.qld.gov.au/mass

**Applicants should retain both this page and Part A for their records.**

**Prescriber information for the applicant may be documented here:**

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part A – Applicant Acknowledgement – Retained by the Applicant**

**1. I confirm that:**

- I have actively participated in the assessment and trial for the aid/s and associated modifications and/or accessories.
- the features and options of the aid/s, and any appropriate alternatives have been fully explained to me by my prescribing health professional.
- the possible cost implications that I may incur as a result of MASS policy or subsidy funding have been explained to me by my prescribing health professional.
- the aid/s prescribed are suitable for my needs.
- I have a safety switch (residual current device) installed in my home and am using a surge protection device (only applicable for MASS subsidy funded mobility and daily living aids that require charging/operation through mains power).

**2. I acknowledge that the aid/s provided by MASS are on permanent loan and:**

- remains the property of MASS, unless advised by MASS in writing.
- will only be used by me and for the purposes prescribed.
- will be maintained by me on a weekly/monthly basis as outlined in the information provided to me with the aid.
- must be returned to MASS when I no longer require its use or it is replaced, unless advised by MASS in writing.
- must not have any repairs and/or modifications carried out without specific prior approval by the local MASS service centre i.e. Brisbane or Townsville.
- MASS takes no responsibility for any injury sustained by me through use of the aid subsidy funded/allocated by MASS.
- unless the equipment is supplied to me with a written notice confirming that it has been tested for electrical safety and that the equipment 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.

**3. I agree to:**

- having photographs/video footage taken to assist with my application (for powerdrive wheelchairs, optional for other aids). Refer to MASS 82 Consent for Photograph/Video Form.
- answer promptly any enquiries made from time to time by MASS service centre as to the condition of the Scheme's aids and my continued need for its safe and effective use.
- notify my local Queensland Health Community Health Centre or local MASS service centre should I cease to be able to use the aid/s safely and effectively.
- use the aid/s within the conditions of MASS.
- inform MASS within 14 days of any change in my residential address, or eligibility for MASS funding subsidy e.g. no longer eligible for a health care card.

**4. I understand that if I have taken ownership of a MASS subsidised aid that:**

- repairs and maintenance become my responsibility.
- insurance cover becomes my responsibility.

**Part A – MASS Privacy Statement – Retained by the Applicant**

**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)

MEDICAL AIDS SUBSIDY SCHEME (MASS)

**Part B – Applicant’s Personal Details**

Title:                      Applicant’s Surname:  
Applicant’s Given Name/s:                      Preferred Name:  
Date of Birth:                      Male                       Female   
Applicant’s Permanent Residential Address:  
  
Suburb/Town:                      Postcode:  
Telephone:                      Mobile:                      Fax:  
E-mail:  
Applicant’s Delivery Address (if different from above):  
  
Suburb/Town:                      Postcode:                      Telephone:  
Applicant’s Postal Address (for correspondence):  
  
Suburb/Town:                      Postcode:

Is the applicant receiving an Extended Aged Care at Home (EACH) or Consumer Directed Care (CDC) High Care package?    Yes  No   
*Note: If the applicant will be receiving an EACH package or CDC High Care package at hospital discharge you should mark “Yes” above.*  
Is the applicant a resident in a Commonwealth funded care facility? Yes  No  Level:  
*Please note: If the answer is Yes, MASS may need to contact the residential care facility to clarify your level of care e.g. high or low care*  
Facility Name:

Has the applicant received prior equipment from MASS                      Yes  No   
Does the applicant receive a Department of Veterans' Affairs benefit?                      Yes  No   
Does the applicant receive Commonwealth Rehabilitation Scheme assistance?                      Yes  No   
*Required by MASS for funding and/or optimal service provision*  
Does the applicant receive HACC services e.g. home respite, home care?                      Yes  No   
Does the applicant identify with Aboriginal descent                      Yes  No   
Does the applicant identify with Torres Strait Islander descent                      Yes  No   
Country of Birth:                      Language spoken at home:  
Does the applicant require an interpreter? Yes  No  Language for Interpreter:

Carer Title:                      Surname:                      Given Name/s:  
Telephone:                      Mobile:                      Fax:  
E-mail:  
Relationship of carer to applicant:  
Postal Address (if different to the applicant's):  
Suburb/Town:                      Postcode:

**MEDICAL AIDS SUBSIDY SCHEME (MASS)**

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part C – Application Requirements**

This application will be returned to the prescriber if all the requirements of the application form, as listed below, are not completed. A letter will also be sent to the applicant explaining the situation.

- Has the front page been retained by the applicant?
- Has Part A been understood and retained by the applicant?
- Has Part B been completed (if applicable, the level of residential care must be documented)?
- Has Part C been completed and signed by the prescriber?
- Has Part G been understood and signed by the applicant?
- Has supporting clinical documentation, e.g. episode of care details, to confirm clinical eligibility been attached?
- Has a quote, diagram or other supporting documentation been attached, if required?
- Is a photocopy (front and back) of the applicant's current eligibility card/form OR signed MASS 84 Proxy Access to Centrelink Information Form attached?
- Has a copy of the application form been retained by the prescriber?

***Brisbane:***

Medical Aids Subsidy Scheme  
 PO Box 281 Cannon Hill Qld 4170  
 (41 Southgate Avenue, Cannon Hill)  
 Telephone: 3136 3524 Fax: 3136 3525  
 Email: mass184@health.qld.gov.au  
 Website: www.health.qld.gov.au/mass

***Townsville:***

Medical Aids Subsidy Scheme  
 PO Box 980 Hyde Park Qld 4812  
 (190 Palmerston Street, Vincent)  
 Telephone: 4775 8000 Fax: 4775 8001  
 Email: mass184@health.qld.gov.au  
 Website: www.health.qld.gov.au/mass

**Part C – Prescriber Details – Required for Return Correspondence and Queries**

**Prescriber details** (required for return correspondence and queries):

Title:                      Surname:                      Given Name/s:

Profession:                      Registration Current?    Yes  No

Organisation Name:

Organisation Street Address:

Suburb:                      Postcode:

Organisational Postal Address:

Suburb:                      Postcode:

Telephone:                      Mobile:

Fax:                      Contact Hours:

E-mail:

I certify that the information contained in Section B of this form is in accordance with the MASS Statewide Prescriber Procedures Manual.

Signature:                      Date:

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part C – Clinical Assessment**

I hereby apply for assistance in obtaining (please specify aid/s):

**Urgent Processing Requests.**  
**Please complete MASS 20 URGENT form and attach to the front of this MASS 20 application form.** Note this information is required for consideration of all urgent requests.

**Applicant's Primary Medical Diagnosis:**  
**Condition impacting on need for mobility/DLA:**

**Applicant's height:** \_\_\_\_\_ **cms** | **Applicant's weight:** \_\_\_\_\_ **kgs** | **Falls: Yes**  **No**

**1. Applicant's permanent stabilised disability that necessitates the requested aid:**  
 Any other relevant medical history:

**2. Mobility/Daily Living Aid/s being applied for:**

<input type="checkbox"/> Wheeled walking aid	<input type="checkbox"/> Manual wheelchair
<input type="checkbox"/> Powerdrive wheelchair	<input type="checkbox"/> Infant/child seated mobility device (buggy)
<input type="checkbox"/> Pressure redistribution cushion	<input type="checkbox"/> Pressure redistrib mattress/Positioning sleep system
<input type="checkbox"/> Bedside commode	<input type="checkbox"/> Custom made bathboard
<input type="checkbox"/> Mobile overtoilet showerchair	<input type="checkbox"/> Transfer bench/Swivel bathseat/Bath hoist, etc
<input type="checkbox"/> Mobile floor hoist (electric/standing)	<input type="checkbox"/> Sling <input type="checkbox"/> Postural modifications

**3. Current medical aid:** What aid, if any, does this applicant currently use in the home environment? (Include MASS plaque numbers where applicable):

**4. Why does this aid need prescribing/replacing?**

<input type="checkbox"/> Hired/borrowed	<input type="checkbox"/> Beyond repair (enclose statement from repairer)
<input type="checkbox"/> Functional deterioration	<input type="checkbox"/> Functional improvement
<input type="checkbox"/> Outgrown	<input type="checkbox"/> Other (describe):

**5. Describe home environment:**

Type of accommodation:

<input type="checkbox"/> Detached house	<input type="checkbox"/> Flat/unit/townhouse
<input type="checkbox"/> Retirement village complex	<input type="checkbox"/> Purpose built/modified for disability
<input type="checkbox"/> Other (describe):	

Type of access:

<input type="checkbox"/> Ground level	<input type="checkbox"/> Able to be negotiated using requested mobility aid
<input type="checkbox"/> Requires modification	<input type="checkbox"/> Ramp (approximate gradient): one (1) in

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**6. Describe applicant's:**  
 Present mode of mobility inside home environment:  
  
 Transfer ability:  
  
 Ability to stand:

**7. Upper limb power and function:** (Fine/gross motor ability, grasp, dominance, muscle strength, endurance, ROM, influence of tone/primitive reflexes/involuntary movements, etc.)  
 Details:

**8. Lower limb power and function:** (Muscle strength, endurance, ROM, influence of tone/primitive reflexes/involuntary movements, balance/coordination, gait patterns, etc.)  
 Details:

**9. Other relevant factors:**  
 Skeletal deformity:  
  
 Muscle atrophy:  
  
 Head/trunk control, sitting balance, standing balance:  
  
 Sensory loss: Vision, hearing, skin sensation, proprioception:  
  
 Perception and cognition: Planning skills, assessed impairment, dementia:  
  
 Living situation: Alone, partner, family, supported accommodation, other:  
  
 ADL assistance required:  
  
 Continence management:  
  
 Additional comments:

**Part C – Aids Justification – complete relevant parts dependent on requested aids**

**A: Wheeled walking aid.**  
 Describe current ability to manoeuvre and control requested wheeled walking aid inside home environment:  
  
 Is the seat able to be used safely? Yes  No   
 Are the hand operated brakes able to be used effectively? Yes  No

**B: Manual wheelchair.**  
 Describe current ability to propel requested manual wheelchair inside home environment:  
 Unable - requires attendant  Uses both hands  
 Uses hand/foot combination  Uses feet  
 Other comments:

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**C: Powerdrive wheelchair.**

Describe current ability to use requested powerdrive wheelchair inside home environment:

Other comments/relevant information:

**Note:** A video recording is required to demonstrate powerdrive wheelchair competency in comparison to a lightweight manual wheelchair and current form of mobility. Refer to MASS Statewide Prescriber Procedures Manual - Powerdrive Wheelchairs for further details.

Refer to MASS Statewide Prescriber Procedures Manual for emergency backup manual wheelchair applications.

**D: Child/Infant seated mobility device (buggy).**

Why is a pram/stroller unsuitable for the applicant?

Why is a manual wheelchair unsuitable for the applicant?

Which functional activities in the home environment will be assisted by the supply of the requested aid?

**E: Pressure redistribution cushion/mattress or positioning sleep system.**

Does the applicant have a history of pressure areas? No  Yes  Describe area and date of last episode:

Has a pressure risk assessment been conducted? Tool \_\_\_\_\_ Score \_\_\_\_\_

Is the applicant able to redistribute pressure independently & effectively? Yes  No

How many hours will the cushion/mattress be used?

Provide the wheelchair seat dimensions that the cushion is to be used on \_\_\_\_\_ mm wide \_\_\_\_\_ mm deep

For mattress or sleep system applications describe the applicant's bed mobility and positioning needs:

Provide information regarding the effectiveness of the prescribed equipment (e.g. no persistent red areas, improvement of existing pressure injuries, etc.)

**F: Mobile overtoilet/showerchair.**

Why does the applicant require a mobile aid to access the bathroom/toilet?

Describe the environment in which the aid is to be used and confirm appropriate access:

Document why other options are not suitable (e.g. why the applicant cannot transfer to a non-mobile chair/toilet aid or use grab rails, etc.):

**G: Hoist/sling.**

Tick style of hoist: Electric  Standing

Tick style of attachment: 2 point spreader  Pivot frame  4 point spreader  Other

Justification for supply of the requested type of hoist:

Justification for style of attachment if not standard 2 point spreader:

Describe the environment in which the aid is to be used and confirm access:





**MEDICAL AIDS SUBSIDY SCHEME (MASS)**

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part D – Applicant's Contact Persons**

I consent to MASS, Queensland Health approaching my personal contacts should the need arise.

The names and addresses of two (2) personal contacts (1 for client owned items) who are aware that their names have been provided to MASS, who do not reside with the applicant and who will always be aware of the applicant's address are:

	Personal contact	Personal contact
Name in full:		
Relationship to applicant:		
Residential address:		
Postal address:		
Telephone:		
Mobile:		
Fax:		
E-mail:		

**Part E – Compensation or Insurance Claims**

Does a Workcover, third party, public risk or any other form of compensation or insurance claim apply for injuries for which MASS assistance is requested?

No  Yes  If yes, please complete details below:

I have  have not  engaged a legal representative to act on my behalf regarding a claim for damages.

Solicitor's Name:

Firm's Name:

Firm's Address:

Suburb:

Postcode:

Telephone:

Fax:

E-mail:

I undertake to repay MASS the cost of assistance provided to me by MASS, should I obtain damages for injuries from any past, present or future claim/s.

I undertake to advise MASS of the progress of my claim for damages. This may be in the form of written communication to MASS from my legal representative.

I provide authority for MASS to write to and provide information to my legal representative named above.

This authority remains valid until revoked by me in writing.

Signature of Applicant/Carer:

Date:

Name:

Signature of Witness:

Date:

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part F – Service Improvement Activities**

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

I agree to participate in MASS service improvement activities (including internal audits and surveys).

Yes  No

Signature of Applicant/Carer:  
(Delete as appropriate)

Date:

Name (Please print):

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 MASS if I withdraw my consent.

**Part G – Applicant Acknowledgement**

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

Signature of Applicant/Carer:

Date:

Name (Please print):



**Medical Aids Subsidy Scheme, Queensland Health  
Proxy Access to Centrelink Information Form**

(This form is used for applicants, 16 years of age and over, to provide consent to MASS staff to access Centrelink concession card information when a photocopy of the concession card is not attached to the MASS application form)

**MASS  
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Medical Aids Subsidy Scheme (MASS) staff, in accordance with the MASS Privacy Statement, are committed to maintain strict confidentiality in all aspects of service delivery. You are assured that this information will remain confidential. Your information will not be divulged without your consent, or if required or authorised by law.

This consent will be used for the sole purpose of authorising Centrelink to provide information to MASS to access your eligibility in relation to assistance or services provided by MASS.

**Applicant Confirmation:**

I, \_\_\_\_\_ authorise Centrelink to confirm with MASS the current status of my Commonwealth benefit and other details as they pertain to my concessional entitlement. This involves electronically matching details I have provided to MASS with Centrelink or Department of Veterans' Affairs (DVA) records to confirm whether or not I am currently receiving a Centrelink or DVA benefit.

I understand this consent, once signed, is effectively only for the period I am a customer of MASS. I also understand that this consent, which is ongoing, can be revoked any time by giving notice to MASS.

I understand that if I withdraw my consent, I will need to provide a copy (both sides) of my concession card to MASS or I may not be eligible for the assistance provided by MASS.

A brochure is available from Centrelink that provides more details about the Centrelink Confirmation eServices or on Centrelink's website at [www.centrelink.gov.au](http://www.centrelink.gov.au)

**Please provide the following Commonwealth benefit card information, which must be in the name of the adult card holder/applicant. Child applicants will be required to provide a copy of their card.**

**Concession Card Provider (please tick):** Centrelink  Department of Veterans' Affairs

**Type of Concession Card** e.g. Health Care Card:

**Applicant's Concession Card Number:**

**Name of Card Holder:**

**Address on Card:**

**Issue Date on Card:**            /            /            **Expiry Date on Card (if applicable):**            /            /

**Applicant/Carer Signature:** ..... **Date Signed:**            /            /

**Post OR Fax completed form to a MASS Service Centre**

*Email:* [mass184@health.qld.gov.au](mailto:mass184@health.qld.gov.au) *Website:* [www.health.qld.gov.au/mass](http://www.health.qld.gov.au/mass)

**Brisbane:** Medical Aids Subsidy Scheme, PO Box 281, Cannon Hill Qld 4170, Phone: 3136 3636 Fax: 3136 3599

**Townsville:** Medical Aids Subsidy Scheme, PO Box 980, Hyde Park Qld 4812, Phone: 4775 8000 Fax: 4775 8001

**Cairns:** Medical Aids Subsidy Scheme, PO Box 1055, Cairns North Qld 4870, Phone: 4226 4500 Fax: 4226 4565

**Mackay:** Medical Aids Subsidy Scheme, PO Box 688, Mackay Qld 4740, Phone: 4965 9456 Fax: 4965 9418

**Office Use Only**

Details and Eligibility Confirmed:    Yes            No  
Date: \_\_\_\_\_ MASS Officer: \_\_\_\_\_

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_