



<p>Medical Aids Subsidy Scheme, Queensland Health</p> <p>SOA Replacement Manual Wheelchair</p> <p>Short Application Form</p> <p>(Use this form for replacement manual wheelchairs – no postural modifications)</p>	<p>MASS20</p> <p>MWC</p> <p>0412</p>
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Part A Section 1 Applicant's Personal Details

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 attached

Title		Surname	
Given Name/s		Preferred Name	
Date of Birth		Male <input type="checkbox"/>	Female <input type="checkbox"/>
Is the applicant receiving an Extended Aged Care at Home (EACH) package or Consumer Directed Care (CDC) High Care package? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Note: If the applicant will be receiving an EACH or CDC High Care package at hospital discharge you should mark "yes".</i>			
Living in Commonwealth Funded Care Facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Level
Facility Name			
Applicant's Permanent Residential Address			
Suburb/Town		Postcode	
Telephone	Mobile	Fax	
Email			
Applicant's Delivery Address (if different from above)			
Suburb/Town	Postcode	Telephone	
Applicant's Postal Address (for correspondence)			
Suburb/Town		Postcode	

Carer Title		Surname		Given Name/s	
Telephone		Mobile		Fax	
Email					
Relationship of carer to applicant					
Postal Address (if different to applicant)					
Suburb/Town		Postcode			

Applicant's contact persons	Personal contact (1)	Personal contact (2)
Name in full		
Relationship		
Telephone		

Applicant's Full Name:

DOB:

Part A Section 2 Applicant Acknowledgement

MASS Privacy Statement

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

Applicant Acknowledgement

1. I confirm that:

- I have actively participated in the assessment for the wheelchair and associated modifications and/or accessories.
- the features and options of the wheelchair, 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 wheelchair prescribed is suitable for my needs.

2. I acknowledge that a manual wheelchair provided by MASS will be owned by MASS and provided to me, on a permanent loan basis therefore:

- I will seek prior authorisation from MASS for any repairs.
- the wheelchair will only be used by me and for the purposes prescribed.
- the wheelchair will be maintained by me on a weekly/monthly basis as outlined in the information provided to me on delivery.
- MASS takes no responsibility for any injury sustained by me through use of the aid funded/subsidised/allocated by MASS.

3. I agree to:

- use the wheelchair within the conditions of MASS.

I hereby apply for assistance in obtaining a REPLACEMENT MANUAL WHEELCHAIR					
I have been informed of <i>MASS Privacy Statement</i> and accept the conditions of the <i>MASS Applicant Acknowledgement</i>					
I DO <input type="checkbox"/> or DO NOT <input type="checkbox"/> give my consent to be involved in Service Improvement Activities e.g. internal audits and surveys					
Do you identify with Aboriginal <input type="checkbox"/> or Torres Strait Islander <input type="checkbox"/> descent?					
I agree to accept the conditions stated in this application. I acknowledge that my information listed in this application is current and correct.					
Applicant/Carer Name		Signature		Date	

Applicant's Full Name:

DOB:

Part A Section 3 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 B – to be completed by a MASS Designated Prescriber in accordance with the MASS Statewide Prescriber Procedure Manual

Part B Section 1 Clinical Assessment (this short form is only for applications for REPLACEMENT MANUAL WHEELCHAIRS without customised seating/postural modifications – use the standard MASS 20 form for all others)

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

Applicant's height		cm	Applicant's weight:		kg
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1. Applicant's permanent stabilised disability that necessitates the replacement manual wheelchair:

Any other relevant medical history:

2. Application for replacement manual wheelchair: (prescriber please tick and sign section 4 to confirm)

wheelchair is primary means of mobility in the home environment

replacement requested is equivalent to existing model MASS wheelchair on loan to client

only accessories required are those available with wheelchair from supplier (no customised seating/postural modifications)

home remains accessible for manual wheelchair

3. Current manual wheelchair requiring replacement:

Plaque no:

Model :	Size (seat width x depth):
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4. Why does the aid need prescribing/replacing?

<input type="checkbox"/> Identified by MASS for replacement <input type="checkbox"/> Functional deterioration <input type="checkbox"/> Outgrown	<input type="checkbox"/> Beyond repair (enclose statement from repairer) <input type="checkbox"/> Functional improvement <input type="checkbox"/> Other (Describe)
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Applicant's Full Name:

DOB:

Part B Section 2 Aids Trialled

Manual Wheelchair(s) Trialled (trial not essential for replacement with same type/size manual wheelchair):

Model/Type	Length and location of trial	Results/comments

SOA Manual Wheelchair Prescription: (Required for all applications)

Brand	Model (include size if applicable)	Trial Supplier

Note:

- Brand and model must be specified, with all accessories included
- Manufacturer's quotation and specification forms for wheelchairs and accessories must be attached
- If a similar aid is held within MASS stock, the stock aid may be issued in lieu
- The requested aid must be from the current SOA list
- *A copy of applicant's current concession card must accompany this application*

Has the aid been successfully trialled in the home environment?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Provide details		
Are accessories required? – please list and clinically justify below:		

Part B Section 3 Prescriber Details (required for return correspondence and queries)

Title	Surname	Given Name/s
Profession	Registration Current?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Organisation Name		
Organisation Street Address		
Suburb	Postcode	
Organisation 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	



**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)

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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

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 *Website:* 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:** _____