

# Applicant Information Sheet for MASS 45 Adult Oxygen: Initial Application and 4 Month Review



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 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.

Domiciliary oxygen is not provided by MASS for hospital inpatients, residents of Commonwealth funded care facilities and for applicants who are current smokers.

## 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 funding assistance.

The MASS designated prescriber completes the application form in accordance with the General and Oxygen sections of the MASS Statewide Prescriber Procedures Manual.

MASS designated oxygen prescribers are:

- Thoracic Physicians
- Specialist General Physicians
- Oncologists
- Palliative Care Physicians
- Cardiologists
- Neurologists

Refer to Oxygen - Designated Prescriber Chart in the MASS Statewide Prescriber Procedures Manual for further details e.g. endorsement requirements for medical practitioners in rural and remote areas.

## Prescriber Information for the Applicant


## Applicant Acknowledgement

- I confirm that:**
- 1** I have been provided with information by my prescribing medical specialist regarding the safety aspects associated with the use of domiciliary oxygen.
  - 2** I am aware oxygen can be a dangerous fire hazard if used in the vicinity of naked flames.
  - 3** I am a non-smoker and I will not allow others to smoke near my oxygen equipment.
  - 4** I will use the oxygen as explained to me by my prescribing medical specialist.

- 
- I acknowledge that:**
- 5** the equipment subsidised by MASS always remains the property of the oxygen supplier.
  - 6** repairs must only be carried out by the oxygen supplier.
  - 7** I am responsible for loss of and / or damage of the oxygen equipment.
  - 8** the oxygen and oxygen equipment will only be used for the purpose for which it was prescribed.
  - 9** MASS takes no responsibility for any injuries sustained through the use of the oxygen and oxygen equipment subsidised by MASS.
  - 10** MASS will no longer be financially responsible for the oxygen equipment when any of the following occur:
    - I am advised by my prescribing medical practitioner that I am no longer clinically eligible to be provided with oxygen through MASS.
    - I am no longer eligible for a Pensioner Concession Card or Health Care Card.
    - I no longer reside in the state of Queensland.
    - I have moved into a Commonwealth funded aged care facility.
    - I do not return the MASS renewal application form by the due date.

- 
- I agree to:**
- 11** immediately contact the oxygen supplier if there is any problem with the oxygen equipment.
  - 12** immediately contact MASS or my local Community Health Centre to organise return of the oxygen equipment when it is no longer required. I understand that this must then be followed by confirmation from my doctor in writing.
  - 13** inform MASS within 14 days of any change in my residential address or eligibility for MASS subsidy e.g. if I am no longer eligible for a Health Care Card.
  - 14** keep in good order the oxygen equipment subsidised by MASS.
  - 15** promptly answer any enquiries made by MASS in relation to my need for continued use of oxygen and related oxygen equipment.
  - 16** (concentrator users only) check with my oxygen supplier for instructions and advice if I decide to power my concentrator with a generator. I understand that generators require a minimum set of specifications for powering concentrators and this may vary between machines.

## 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.



# MASS 45 Adult Oxygen: Initial Application and 4 Month Review

This form is used for all initial domiciliary oxygen applications and the 4 month review application

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</i> specify	

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

Suburb / town		Postcode
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**6 Does the applicant receive HACC services?** (e.g. home respite, home care)  Yes  No

**7 Is the applicant receiving an Extended Aged Care at Home package?**  Yes  No

**8 Is the applicant a resident in a Commonwealth funded care facility?**  Yes  No

If yes, level <input type="checkbox"/> High <input type="checkbox"/> Low	Facility name
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**9 Does the applicant receive Commonwealth Rehabilitation Scheme assistance?**  Yes  No

**10 Does the applicant receive a Department of Veterans' Affairs benefit?**  Yes  No

**11 Does the applicant receive other assistance?** (e.g. Dept of Communities / Disabilities, Palliative Care services)  Yes  No

If yes, name

**12 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

**13 Country of birth**

Australia Other

**14 Language spoken at home**

English Other

### Carer Information

**15 Name**

Title	Family name
Given name(s)	

**16 Contact information**

Telephone	Fax
Mobile	
Email	

**17 Relationship to applicant**

**18 Postal address**

Suburb / town		Postcode
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**MASS 45  
Adult Oxygen: Initial Application  
and 4 Month Review**

Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

**Alternate Contact Persons**

**19 Alternate 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 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 1	Personal contact 2
Name in full		
Relationship to applicant		
Residential address		
Postal address		
Telephone		
Mobile		
Fax		
Email		

**Compensation or Insurance Claims**

**20 Does a WorkCover, third party, public risk or any other form of compensation or insurance claim apply for injuries for which assistance from MASS, Queensland Health is requested?**

- Yes, please complete details below:
- No, go to the next section, *Service Improvement Activities*

- 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

Email




- 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.

**Applicant / Carer  
signature**

Print name

Date



**Witness  
signature**

Print name

Date

# MASS 45 Adult Oxygen: Initial Application and 4 Month Review

Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

## Service Improvement Activities

21 I agree to participate in MASS 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 07 3136 3614. I understand that there will be no effect to service provision by MASS if I withdraw my consent.


## Applicant Acknowledgement

22  I am a non-smoker and I will not allow others to smoke near my oxygen equipment.

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

24  I acknowledge that my information listed in this application is current and correct.

25 Applicant / Carer signature



Print name

Date

/  /

## PART B To be completed by the prescriber

### Clinical Assessment

1 What type of application is this?

Initial application (measurements required)

4 month review application (repeat measurements required for some categories as per the MASS Statewide Prescriber Procedures Manual)

If there are clinical concerns when arranging tests for a particular applicant, the prescriber should contact the MASS Clinical Advisor prior to organising or conducting the tests.

2 What is the predominant medical condition requiring oxygen therapy? (tick only one)

#### Cardiac

Angina, IHD, CAD

CCF

Congenital HD

Pulmonary Arterial

Hypertension

Other cardiac (detail below)

#### Respiratory

COPD

Cor Pulmonale

Cystic Fibrosis

Interstitial Fibrosis

Life Threatening Asthma

Other respiratory (detail below)

#### Malignancy

Metastatic Lung (detail below)

Primary Lung

Other (specify)

3 Have you provided the applicant / carer with the MASS Adult Oxygen Information and Safety Form (appendix to this application form)?

Yes  No

4 Is the applicant a current smoker?

Yes  No

5 Has the applicant been seen by a member of the Palliative Care service?

Yes  No

6 What are the applicant's measurements?

Height

cm

Weight

kg

Body Mass Index (BMI)

kg/m<sup>2</sup>

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**and 4 Month Review**

Family name:

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**Indication for Oxygen Therapy Categories and measurements required**

**7** Has the applicant had an acute deterioration or exacerbation in the six weeks prior to these measurements?  Yes  No

**8** Select and complete one category only in relation to the predominant medical condition

Measurements are to be provided by or in consultation with a specialist physician.

**Chronic hypoxaemia category**

NB: Applicants should be on room air for a period prior to the test (preferably 20–30 minutes if safe)

**i** Arterial blood gas estimations on room air at rest (required for initial and 4 month review application)

Date	PaO <sub>2</sub> mmHg	PaCO <sub>2</sub> mmHg	pH	CO <sub>2</sub> retainer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time off the oxygen prior to test
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**OR**

**ii** For applicants in remote areas only when arterial blood gas estimations are unavailable

Oximetry on room air at rest (required for initial and 4 month review application)	Date	At rest %	Time off the oxygen prior to test
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**Hypoxaemia with exercise category**

NB: Applicants should be on room air for a period prior to the test (preferably 20–30 minutes if safe)

**i** Arterial blood gas estimations on room air at rest (required for initial application only)

Date	PaO <sub>2</sub> mmHg	PaCO <sub>2</sub> mmHg	pH	CO <sub>2</sub> retainer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time off the oxygen prior to test
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**AND**

**ii** Exercise oximetry study (required for initial and 4 month review application)

Oximetry exercise test both on room air and on oxygen to objectively demonstrate desaturation and response to oxygen.

	On room air	On oxygen	Demonstrated improvement on oxygen:	
At rest	%	%	Distance:	m
After 6 minute walk test	%	%	SaO <sub>2</sub>	%
Distance walked in 6 minutes	m	m		

For applicants in *remote areas only*, when arterial blood gas estimations are unavailable (i) above does not apply.

**Nocturnal hypoxaemia category**

NB: Applicants should be on room air for a period prior to the test (preferably 20–30 minutes if safe)

**i** Arterial blood gas estimations on room air at rest (required for initial application only)

Date	PaO <sub>2</sub> mmHg	PaCO <sub>2</sub> mmHg	pH	CO <sub>2</sub> retainer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Time off the oxygen prior to test
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**AND**

**ii** Nocturnal oximetry study (required for initial application only)

Nocturnal serial oximetry, on room air with readings at regular intervals throughout the sleep period is required to objectively demonstrate oxygen desaturation. Please attach **1)** copy of oximetry readings or sleep study report and **2)** record the percentage of sleep period with desaturation at 88% or less.

For applicants in *remote areas only*, when arterial blood gas estimations are unavailable (i) above does not apply.

Medical Aids Subsidy Scheme (MASS) Queensland Health  <b>MASS 45</b> <b>Adult Oxygen: Initial Application          and 4 Month Review</b>	(Affix identification label here if available)  Family name:  Given name(s):  Date of birth: <span style="float: right;">Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> I</span>
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**Life threatening asthma category**

A thoracic physician must submit applications under this category. A letter confirming the life threatening condition requiring oxygen must be attached to the application form (required for initial and 4 month review application).

**Letter attached**  Yes  No

**Cardiac category**

A cardiologist or specialist physician must submit applications under this category

✓	Specify condition	Requirements
<input type="checkbox"/>	Pulmonary arterial hypertension	Demonstrated oxygen desaturation on oximetry or arterial blood gases (at rest, on exercise or nocturnal) is required
<input type="checkbox"/>	Severe intractable angina when nothing further can be offered in the way of drug therapy or cardiac surgery	No arterial blood gas estimations or oximetry measurements are required
<input type="checkbox"/>	Recurrent episodic acute pulmonary oedema or severe chronic cardiac failure, when no further drug therapy or surgical intervention is possible or while awaiting heart transplantation	No arterial blood gas estimations or oximetry measurements are required

**Neurological category**

A neurologist or specialist physician must submit applications under this category. A letter confirming the neurological condition requiring oxygen must be attached to the application form (required for initial and 4 month review application).

**Letter attached**  Yes  No

**Other conditions or co-morbidities category**

A specialist physician must submit applications under this category following discussion with the MASS Clinical Advisor.

**Oxygen Equipment**

**9 Backup cylinders are only provided in specific circumstances as detailed below**

Applicant's condition is considered by the treating medical practitioner to be life threatening in the event of power or equipment failure

Applicant is prescribed continuous oxygen for 24 hours per day at a flow rate of   L/min

**Emergency Backup Cylinder for Concentrator Users** MASS will subsidise either 3 x "C" or 3 x "CL" or 1 x "E" size emergency backup cylinder(s) per six month period for use in the event of power or equipment failure.

**10 Oxygen equipment requested** (alternate packages not available with standard packages)

Standard Packages	Alternative Packages	Accessories
<input type="checkbox"/> Concentrator Package  <b>Is backup required?</b> (indicate type) <input type="checkbox"/> Emergency Backup 'C' Size Cylinder (400 litre), <b>OR</b> <input type="checkbox"/> Emergency Backup 'CL' Size Cylinder (690 litre) , <b>OR</b> <input type="checkbox"/> Emergency Backup 'E' Size Cylinder (4000 litre)	Maximum 4 cylinders only per month <input type="checkbox"/> 'C' Size (400 litre) Portable Cylinder Package (Lung Transplantation or Hypoxaemia with Exercise applicants only) <b>OR</b> <input type="checkbox"/> 'CL' Size (690 litre) Portable Cylinder Package (Life Threatening Asthma or Hypoxaemia with Exercise applicants only) <b>OR</b> <input type="checkbox"/> 'E' Size (4000 litre) Cylinder Package	<input type="checkbox"/> Cannula and Tubing <b>OR</b> <input type="checkbox"/> Mask and Tubing

**11 Does the applicant use a wheelchair or wheeled walking aid?**  Yes  No

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Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

**Oxygen Prescription**

**12 Flow rates**

Continuous

Exercise

Nocturnal

Asthma

Recommended usage

L/min

L/min

L/min

L/min

hours per 24 hours

**Applicant's General Practitioner**

**13 Name (in full)**

**14 Address**

Suburb / town

Postcode

**15 Telephone**

**Continuing Reassessment and Follow-up** Prescriber or designated person to complete

**Compulsory MASS oxygen review appointment**

This section must be completed for the **initial application only** to ensure ongoing MASS funding

**16 Reviewing specialist**

Name

Telephone

**17 Date of review appointment** (must be 3 to 4 months after this initial application)

**18 Full details of arrangements for follow-up** (e.g. private / outpatient clinic, address, etc.)

**Hospital Community Liaison Nurse / Discharge Planner / Receptionist**

**19 Name and contact information**

Name

Telephone

Pager

Position

Facility / Department

**20 Has a community health / domiciliary nursing service referral been made?**

Yes, please provide name and contact details of agency

No, please refer this applicant to the local Community Health Centre for clinical follow-up regarding oxygen therapy.

# MASS 45

## Adult Oxygen: Initial Application and 4 Month Review

Family name:

Given name(s):

Date of birth:

Sex:  M  F  I

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

21 Family name

22 Given name(s)

23  Medical specialist (state speciality)

**OR** Other (indicate GP, RMO)

24 Provider number

25 Facility

26 Department

27 Address

Suburb / town

Postcode

Telephone

Fax

Mobile

Email

28 Signature

I certify that the information contained in this application is in accordance with the MASS Statewide Prescriber Procedures Manual.

Date

### Specialist Endorsement

Refer to guidelines for endorsement requirements

29 Family name

30 Given name(s)

31 Speciality

32 Facility

33 Department

34 Address

Suburb / town

Postcode

35 Telephone

Contact hours

### Application Requirements Prescriber or designated person to complete

This application will be returned to the prescriber if all the requirements of the application form, as listed below, are not completed and signed. In addition a letter will be forwarded to the applicant explaining the situation.

- The Applicant Information Sheet has been understood and retained by the applicant
- Part A has been completed and signed by applicant / carer
- Part B has been completed and signed by the prescriber
- Supporting clinical documentation to confirm clinical eligibility has been included
- A photocopy (front and back) of the applicant's current eligibility card / form **OR** signed *MASS 84 Proxy Access to Centrelink Information Form* is attached
- A copy of the application form has been retained by the prescriber

**Please post or fax completed applications to one of the following MASS service centres**

#### Brisbane

Medical Aids Subsidy Scheme  
PO Box 281, Cannon Hill Qld 4170  
Telephone: 07 3136 3510 | Fax: 07 3136 3500  
Email: mass184@health.qld.gov.au  
Website: www.health.qld.gov.au/mass

#### Mackay

Medical Aids Subsidy Scheme  
PO Box 688, Mackay Qld 4740  
Telephone: 07 4965 9456 | Fax: 07 4965 9418  
Email: mass184@health.qld.gov.au  
Website: www.health.qld.gov.au/mass