Applicant Information Sheet for MASS 46 Adult Oxygen: Annual Re-application 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
- Cardiologists
- General Practitioners
- Specialist General Physicians
- Palliative Care Physicians
- Oncologists
- 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

v1.00 - 02/2012

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.

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 46
Adult Oxygen: Annual Re-application

This form is used for all annual domiciliary oxygen re-applications

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

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PART A To be completed by the applicant / carer

Applicant's Personal Details

1 Name

Title	Family name
Given name(s)	
Preferred name ☐ First name *or* 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

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

Suburb / town | Postcode

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 ☐ High ☐ Low	Facility name

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

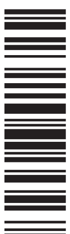
Mobile

Email

17 Relationship to applicant

18 Postal address

Suburb / town | Postcode



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v1.00 - 02/2012

Medical Aids Subsidy Scheme (MASS)
Queensland Health

MASS 46
Adult Oxygen: Annual Re-application

(Affix identification label here if available)

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		

Service Improvement Activities

20 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.

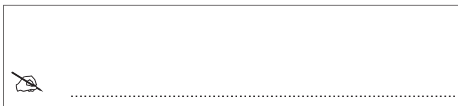
Applicant Acknowledgement

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

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

23 ☐ **I acknowledge that my information listed in this application is current and correct.**

24 Applicant / Carer signature



Print name

Date / /

PART B To be completed by the prescriber

Clinical Assessment

1 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 over page)

Respiratory
- ☐ COPD
- ☐ Cor Pulmonale
- ☐ Cystic Fibrosis
- ☐ Interstitial Fibrosis
- ☐ Life Threatening Asthma
- ☐ Other respiratory (detail over page)

Malignancy
- ☐ Metastatic Lung (detail over page)
- ☐ Primary Lung

Medical Aids Subsidy Scheme (MASS) Queensland Health	(Affix identification label here if available)
MASS 46 **Adult Oxygen: Annual Re-application**	Family name:
	Given name(s):
	Date of birth: Sex: ☐ M ☐ F ☐ I

Other (specify)

2 **Is the applicant a current smoker?** ☐ Yes ☐ No

Oxygen Equipment

3 **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.

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

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

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

Oxygen Prescription

6 **Flow rates**

Continuous	Exercise	Nocturnal	Asthma	Recommended usage
L/min	L/min	L/min	L/min	hours per 24 hours

Applicant's General Practitioner

7 **Name (in full)**

8 **Address**

Suburb / town | Postcode

9 **Telephone**

Medical Aids Subsidy Scheme (MASS)
Queensland Health

MASS 46
Adult Oxygen: Annual Re-application

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Prescriber Details To be completed in full for all applications

10 Family name

11 Given name(s)

12 ☐ Medical specialist (state speciality)

☐ **OR** Other (indicate GP, RMO)

13 Provider number

14 Facility

15 Department

16 Address

Suburb / town | Postcode

Telephone | Fax

Mobile

Email

17 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

18 Family name

19 Given name(s)

20 Speciality

21 Facility

22 Department

23 Address

Suburb / town | Postcode

24 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