

Applicant Information Sheet for MASS 47 Child and Paediatric Oxygen: Application Form



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)

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.

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:

- Paediatric Thoracic Physicians
- Paediatricians
- Neonatologists
- Cardiologists
- Neurologists

Refer to Oxygen - Designated Prescriber Chart in the MASS Statewide Prescriber Procedures Manual for further details.

Prescriber Information for the Applicant / Parent / Carer

Applicant / Parent / Carer Acknowledgement

- I confirm that:**
- 1** I have been provided with information by the 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 the oxygen equipment.
 - 4** I will use the oxygen as explained to me by the 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 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 the doctor in writing.
 - 13** inform MASS within 14 days of any change in the residential address or eligibility for MASS subsidy e.g. 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 the need for continued use of oxygen and related oxygen equipment.
 - 16** (concentrator users only) check with the oxygen supplier for instructions and advice if I decide to power the concentrator with a generator. I understand that generators require a minimum set of specifications for powering concentrators and this may vary between machines (only applicable for concentrator applicants).

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 47 Child and Paediatric Oxygen: Application Form

This form is used for all initial applications, 6 month and annual review applications for paediatric oxygen

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

/	/
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Sex

Male
 Female

3 Permanent residential address

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

If yes, name

8 Is the applicant of Aboriginal or Torres Strait Islander origin? Yes, Aboriginal Yes, Torres Strait Islander No

For applicants of both Aboriginal and Torres Strait Islander origin, tick both 'Yes' boxes.

9 Country of birth

Australia Other

10 Language spoken at home

English Other

Carer Information

11 Name

Title	Family name
Given name(s)	

12 Contact information

Telephone	Fax
Mobile	
Email	

13 Relationship to applicant

14 Postal address

Suburb / town		Postcode
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Alternate Contact Persons

15 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

16 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

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(Affix identification label here if available)

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Service Improvement Activities

17 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 / Parent / Carer Acknowledgement

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

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

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

21 Applicant / Parent / Carer signature



Print name

Date

/ /

PART B To be completed by the prescriber

Clinical Assessment

1 What type of application is this?

Initial application (specialist assessment and measurements*)

6 month review application (specialist assessment and measurements*)

12 month review application (specialist assessment and measurements*)

*Refer to MASS Statewide Prescriber Procedures Manual for categories requiring repeat measurements.

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

Congenital HD

Pulmonary

Hypertension

Other cardiac

(detail below)

Respiratory

Life Threatening Asthma

Chronic Neonatal Lung Disease

Cystic Fibrosis

Interstitial Fibrosis

Respiratory failure secondary to myopathy

Other respiratory (detail below)

Malignancy

Metastatic Lung

(detail below)

Primary Lung

Other (specify)

3 Have you provided the applicant / parent / carer with the MASS Child Oxygen Information and Safety Form (appendix to this application form)? Yes No

4 Has the applicant been seen by a member of the Palliative Care service? Yes No

5 What are the applicant's measurements?

Height

cm

Weight

kg

Body Mass Index (BMI)

kg/m²

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Indication for Oxygen Therapy Categories and measurements required

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

Hypoxaemia category

Hypoxaemia demonstrated by oximetry at rest. Oximetry should be carried out for a minimum of two hours with recordings at 5 minute intervals if serial reading is not available. Serial oximetry reading is preferred.

Date	At rest (awake) %	Minimum saturation (asleep) %	Baseline saturation %

Life threatening asthma category

A paediatric thoracic physician must submit applications under this category.

Details of the condition requiring oxygen must be provided below

Cardiac category

A cardiologist or paediatric thoracic physician must submit applications under this category.

Details of the condition requiring oxygen must be provided below

Neurological category

A neurologist must submit applications under this category.

Details of the condition requiring oxygen must be provided below

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Other conditions category

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

Details of the condition requiring oxygen must be provided below

Oxygen Equipment

7 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 only subsidise 1 x "E" size emergency backup cylinder per six month period for use in the event of power or equipment failure.

8 Oxygen equipment requested (alternate packages not available with standard packages)

Standard Packages	Supplementary Packages	Accessories
<input type="checkbox"/> 'C' size (400 litre) Cylinder package and 'E' Size Cylinder (4000 litre) Cylinder OR <input type="checkbox"/> Paediatric Concentrator and 'C' size (400 litre) Cylinder package <input type="checkbox"/> Emergency Backup 'E' size Cylinder package (complete section below)	<input type="checkbox"/> 'CL' Size (690 litre) Portable Cylinder (supplementary package for rural / remote areas and / or extensive travel purposes) (complete section below)	<input type="checkbox"/> Cannula and Tubing OR <input type="checkbox"/> Mask and Tubing

Standard paediatric concentrator and cylinder packages include low flow meter and trolley / carry bag.

Justification for Supplementary Packages (e.g. hours of portable oxygen usage per 24 hours, rural / remote or extensive travel requirements). Please provide details:

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

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Oxygen Prescription

10 Flow rates

Continuous

Exercise

Nocturnal

Asthma

Recommended usage

L/min

L/min

L/min

L/min

hours per 24 hours

Applicant's General Practitioner

11 Name (in full)

12 Address

Suburb / town

Postcode

13 Telephone

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

Compulsory MASS oxygen initial 6 month review appointment

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

14 Reviewing specialist

Name

Telephone

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

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

Hospital Community Liaison Nurse / Discharge Planner / Receptionist

17 Name and contact information

Name

Telephone

Pager

Position

Facility / Department

18 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.

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(Affix identification label here if available)

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Sex: M F I

Prescriber Details To be completed in full for all applications

19 Family name

20 Given name(s)

21 Medical specialist (state speciality)

OR Other (indicate GP, RMO)

22 Provider number

23 Facility

24 Department

25 Address

Suburb / town

Postcode

Telephone

Fax

Mobile

Email

26 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

27 Family name

28 Given name(s)

29 Speciality

30 Facility

31 Department

32 Address

Suburb / town

Postcode

33 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 / parent / carer
- Part A has been completed and signed by applicant / parent / 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