



Medical Aids Subsidy Scheme, Queensland Health

**Medical Grade Footwear and Orthoses
Application Form**

(This form is used for orthoses and medical grade footwear applications)

MASS

60

0511

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.

Medical Grade Footwear (MGF) is not provided by MASS for people who are high care residents of Commonwealth funded care facilities.

Orthoses (other than in-shoe orthotics as part of an MGF application) are not provided by MASS for people who are seen on behalf of a public hospital 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 Medical Grade Footwear or Orthoses sections of the MASS Statewide Prescriber Procedures Manual.

MASS designated prescribers are medical specialists from the following groups noted below:

Medical Grade Footwear (MGF)

Private Sector medical specialists as follows:

- Orthopaedic surgeons - Rehabilitation specialists - Rheumatologists - Geriatricians
- Endocrinologists - Vascular surgeons

Public sector podiatrists (A trial is being conducted from 1st November 2008, whereby public sector podiatrists are approved as prescribers of medical grade footwear including in-shoe orthotics for MASS eligible clients. The continuation of this trial is subject to monitoring and review).

Orthoses (working in a *private* capacity only)

- Orthopaedic surgeons - Rehabilitation specialists - Rheumatologists - Geriatricians.

MEDICAL AIDS SUBSIDY SCHEME (MASS)

Other medical specialists in the private sector who wish to be MASS designated prescribers may apply in writing to the MASS Clinical Advisor.

Refer to the Designated Prescriber Charts in the MASS Statewide Prescriber Procedures Manual for medical grade footwear and orthoses for further details.

Post OR Fax completed applications to a MASS Service Centre

Brisbane:

Medical Aids Subsidy Scheme
PO Box 281, Cannon Hill Qld 4170
Telephone: 3136 3510 Fax: 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: 4965 3931 Fax: 4965 3795
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:

Part A – Applicant Acknowledgement – Retained by the Applicant

1. I confirm that:

- I have actively participated in the assessment 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 prescriber
- the possible cost implications that I may incur as a result of MASS policy or subsidy funding have been explained to me by my prescriber
- the aid/s prescribed is/are suitable for my needs
- the aid/s will only be used by me for the purposes prescribed.

2. I understand that:

- MASS takes no responsibility for any injury sustained by me through use of the aid subsidy funded by MASS.

3. I agree to:

- use the aid/s within the conditions of MASS
- inform MASS within 3 weeks of receipt of the aid/s of my satisfaction/dissatisfaction with the aid/s
- be willing to participate in a post delivery follow-up with the supplier if it does not meet my functional need within 3 weeks of receipt of the aid/s
- inform MASS within 4 weeks of receipt of the aid/s of my satisfaction/dissatisfaction with the aid
- inform MASS within 14 days of any change in my residential address or eligibility for MASS subsidy funding e.g. no longer eligible for a health care card.

Part A – MASS Privacy Statement

The information collected in this application ("your information") is required by Queensland Health to assess if you are eligible for subsidy funding for the supply of aids and equipment and to assist us in processing your application. [This is authorised under the Medical Aids Subsidy Scheme (MASS) which administers the subsidy].

Queensland Health protects your privacy by collecting, using, storing and disclosing the personal information it holds about you in accordance with **Information Standard 42A (IS42A)** which sets out the privacy rules that apply to Queensland Health.

Your information may be disclosed to your prescribing health professional (for further clinical management), your carer or to those parties requiring the information to provide you with the aids and equipment and services you are entitled to receive through MASS or if required or authorised by law.

Your information will not be disclosed to any other third parties without your consent.

If the information you give us is not complete or accurate, we may not be able to process your application. If any details change or if you find the personal information we hold about you is inaccurate, please contact us and we will take reasonable steps to ensure it is corrected.

For more information on the Queensland Health Privacy Policy, visit the website at www.health.qld.gov.au/privacy.

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

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

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:

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:

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

Does the applicant receive Commonwealth Rehabilitation Scheme assistance? Yes No

Does the applicant receive other funding assistance? Please name:

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 and signed. In addition a letter will be forwarded 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 D been understood and signed by the applicant?
- Has supporting clinical documentation to confirm clinical eligibility been included?
- Has a quote for the medical grade footwear, including in shoe orthotics, been included?
- Has a quote for orthoses been included?
- 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?

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: 3136 3510 Fax: 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: 4968 3931 Fax: 4968 3829
Email: mass184@health.qld.gov.au
Website: www.health.qld.gov.au/mass

Part C – Applicant's Current Mobility Aids

What medical grade footwear or orthosis, if any, does the applicant currently use in the home environment?

Is this the same as now being requested: Yes No

Who made this aid?

Who paid for this aid?

How many months ago was it made?

What other mobility aids are used around the home (e.g. wheelchair, etc.)

MEDICAL AIDS SUBSIDY SCHEME (MASS)

Applicant's Full Name: _____ DOB: _____

Part C – Clinical Assessment

- (i) Diagnosis relevant to this application:
- (ii) Date of onset of the condition:
- (iii) Describe the applicant's functional disability and its impact on mobility. Please comment on any deformity, spasm, pain, sensory loss etc:
- (iv) Indicate anatomical site affected (e.g. forefoot, hindfoot):
- (v) Functional outcome expected from use of aid:
- | | |
|---|---|
| <input type="checkbox"/> Hold/maintain position | <input type="checkbox"/> Enhance transfers |
| <input type="checkbox"/> To assist mobility | <input type="checkbox"/> Other (supply details) |
- (vi) Is the applicant able to weight bear? Yes No
- (vii) Describe any factors which may affect the type of item/components/modifications prescribed (e.g. fluctuating oedema, loss of sensation)

Part C – Medical Grade Footwear (MGF) Prescription (including in-shoe orthotics)

- (i) Description of footwear required (please tick):
- | |
|---|
| <input type="checkbox"/> Prefabricated medical grade footwear (e.g. extra width/extra depth footwear) |
| <input type="checkbox"/> Customised medical grade footwear (i.e. specific individualised alterations/additions to footwear) |
| <input type="checkbox"/> Custom made medical grade footwear (requires individual moulds and personalised specifications, patterns and lasts for both feet). <i>If selected, please state why "custom made" footwear is the only prescription suitable for this applicant.</i> |
- (ii) Modification/components required (including any in-shoe orthotics):

MEDICAL AIDS SUBSIDY SCHEME (MASS)

Applicant's Full Name: _____ DOB: _____

Part C – Orthoses Prescription

Note: A request for in-shoe orthotics must be completed as part of the medical grade footwear prescription on the previous page.

- (i) Description of orthosis:

- (ii) Orthosis/orthoses required: Left Right Bilateral
- (iii) Preferred materials to be used (e.g. metal/plastic etc.):

- (iv) Modifications/components required:

Part C – Review Process

- If there is a problem with the completed item/s, are you willing to undertake a review process?
- Yes.
 - No, I delegate the review process to the applicant's *treating* allied health professional.
(In rural and Remote areas only)

Please note that this review process cannot be delegated to the supplier of the requested item/s.

Details of delegated treating allied health professional (if applicable):

Name: _____ Profession: _____
Address: _____
Telephone: _____ Fax: _____
E-mail: _____

If applicable, the delegated treating allied health professional must be advised by the prescriber that he/she is to review the suitability of the aid and provide the applicant with functional information in relation to the use of the aid.

Part C – Prescriber Details – to be completed in full

Title: _____ Surname: _____ Given Name/s: _____
Profession: _____ Registration Number: _____
Specialty: _____ Provider Number: _____
Address: _____
Suburb: _____ Postcode: _____
Telephone: _____ Fax: _____
E-mail: _____

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

Signature: _____ **Date:** _____

MEDICAL AIDS SUBSIDY SCHEME (MASS)

Applicant's Full Name: _____ **DOB:** _____

Part D – 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, Queensland Health 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, Queensland Health 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 my legal representative named above, and to provide the legal representative with written details and costs of the aids and equipment that MASS has provided and currently provides to me.

Signature of Applicant/Carer:

Date:

Name:

Signature of Witness:

Date:

Part D – Applicant Acknowledgement

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

Signature of Applicant/Carer:

Date:

Name (Please print):

Part D – 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:

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.