Applicant Information Sheet for MASS 20 DLA/MOB

Daily Living Aids and Mobility Equipment including CAEATI Subsidy Funding application

The person who will receive the equipment (the Applicant) should retain this section for their records.

Eligibility - MASS Subsidy

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**

To confirm eligibility: Please provide a signed consent to access Centrelink information (MASS 84 Proxy Access to Centrelink Information Form) OR a copy of both sides of the eligibility card.

Clinical eligibility will be determined by the Medical Aids Subsidy Scheme (MASS) Clinical Advisor based on information provided by the prescribing therapist as required in the MASS General Guidelines (http://www.health.qld.gov.au/mass/)

Eligibility - CAEATI Subsidy

All CAEATI applicants will need to have been deemed eligible through a Department of Communities, Child Safety & Disability Services (DCCSDS) assessment prior to submitting an application.

Please obtain your DCCSDS reference number (BIS Number) to be included on your application.

How to Apply - MASS and CAEATI

Applicants wishing to apply for subsidy funding for aid/s through MASS/CAEATI must consult an Occupational Therapist (OT), Physiotherapist (PT), Rehabilitation Engineer (RE) or for rural and remote areas only, a Registered Nurse in conjunction with an Occupational Therapist or Physiotherapist. The clinician will provide an assessment of your needs and assist you in choosing the most appropriate equipment for your needs.

- **To apply for MASS subsidy funding please complete Sections A, B and C of this form.**
- **To apply for CAEATI subsidy funding please complete Sections A, B and D of this form.**
- **To apply for both MASS and CAEATI subsidy funding please complete Sections A, B , C and D of this form.**

Applicant Acknowledgement

I confirm that:

1. **I have actively participated in the assessment and trial of aid/s and associated modifications and accessories.**
2. **the features and options of the aid/s, and any appropriate alternatives have been fully explained to me by my prescribing health professional.**
3. **the possible cost implications that I may incur as a result of MASS/CAEATI policy or subsidy funding have been explained to me by my prescribing health professional.**
4. **the aid/s prescribed are suitable for my needs.**
5. **I have a safety switch/residual current device installed in my home (only applicable for MASS subsidy funded mobility and daily living aids that require charging/ operation through mains power).**

I acknowledge that the aid/s provided by MASS are on permanent loan and:

6. **remain the property of MASS, unless advised by MASS in writing.**
7. **will only be used by me for the purposes prescribed.**
8. **will be maintained by me on a weekly/monthly basis as outlined in the information provided to me with the aid.**
9. **must be returned to MASS when I no longer require its use or it is replaced, unless advised by MASS in writing.**
10. **could be allocated from existing MASS stock. MASS may choose to reallocate suitable aid/s and not purchase new.**

11 must not have any repairs and/or modifications carried out without specific prior approval by the local MASS service centre i.e. Brisbane or Townsville.

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

13 unless the equipment is supplied to me with written notification that it has been tested for electrical safety and that the equipment was found to be electrically safe, I should assume that it has not been tested and where the assumption applies, Queensland Health makes no warranty as to the electrical safety of the equipment.

I agree to:

14 Having photographs/video footage taken to assist with my application (optional). Refer to *MASS 82 Consent* for Photograph/Video Form.

15 answer promptly any enquiries made from time to time by MASS service centre as to the condition of the aids and my continued need for its safe and effective use.

16 notify my local Queensland Health Community Health Centre or local MASS service centre should I cease to be able to use the aid/s safely and effectively.

17 use the aid/s within the conditions of MASS.

18 inform MASS within 14 days of any change in my residential address or eligibility for MASS subsidy funding assistance. For example:
- no longer eligible for a health care card;
- in receipt of a Home Care Package level 3 or 4;
- in receipt of a Consumer Directed Care (CDC) package level 3 or 4;
- admission to a residential facility etc.

I understand that if I have taken ownership of a MASS subsidised aid that:

19 repairs and maintenance become my responsibility.

20 insurance cover becomes my responsibility.

I acknowledge that the aid/s provided by CAEATI:

21 will be deemed to be my property.

22 will not provide payment for ongoing maintenance and/or repairs. All repairs and maintenance will be my responsibility

23 will be maintained by me on a weekly/monthly basis.

24 are my responsibility to insure.

25 are my property. CAEATI takes no responsibility for any injury sustained by me through use of the aid.

MASS Privacy Statement

YOUR PRIVACY: The Queensland Health, Medical Aids Subsidy Scheme (MASS) collects administrative, demographic and clinical data as part of the MASS application processes, in accordance with the *Information Privacy Act 2009* and *Health Services Act 2011*, in order to assess your 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, community care 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.

Please send completed form via post or email to:

Medical Aids Subsidy Scheme, Brisbane
PO Box 281, Cannon Hill Qld 4170
Telephone: 3136 3524 Fax: 3136 3525
Email:
MASS-Equipment@health.qld.gov.au
MASS-CAEATI@health.qld.gov.au
Website: www.health.qld.gov.au/mass

Medical Aids Subsidy Scheme, Townsville
PO Box 980, Hyde Park Qld 4812
Telephone: 4433 8000 Fax: 4433 8001
Email:
MASS-Equipment-TSV@health.qld.gov.au
MASS-CAEATI@health.qld.gov.au
Website: www.health.qld.gov.au/mass

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB

(including CAEATI Subsidy Funding)

Daily Living Aids and Mobility Equipment

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART A – Applicant Details Complete for MASS/CAEATI funding consideration

Applicant's Personal Details

1 Name

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

2 MASS reference number (if known)

3 Date of birth **Sex** ☐ Male ☐ Female

4 Permanent residential address

Suburb / town	Postcode
Telephone	Fax
Mobile	
Email	

5 Delivery address ☐ Same as residential address

Suburb / town	Postcode

6 Postal address ☐ Same as residential address (for correspondence)

Suburb / town	Postcode

7 Is the applicant receiving a Home Care Package? ◯ Yes ◯ No

Note: If the applicant will be receiving a Home Care package or CDC High Care Package at hospital discharge you should mark 'Yes'.

◯ Level 1 ◯ Level 2 ◯ Level 3 ◯ Level 4

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

Enter ACFI Score of L (Low), M (Medium) or H (High) for:
ADL _____ Behaviour_____ Complex Care_____

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

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

If *yes*, name

11 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

12 Country of birth

☐ Australia Other

13 Language spoken at home

☐ English Other

Carer Information

14 Name

Title	Family name
Given name(s)	

15 Contact information

Telephone	Fax
Mobile	
Email	

16 Relationship to applicant

17 Postal address

Suburb / town	Postcode

v3.00 10/2015

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Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB

(including CAEATI Subsidy Funding)

Daily Living Aids and Mobility Equipment

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Alternate Contact Persons

18 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

Name in full	Relationship to applicant
Address	
Telephone	Mobile
Fax	Email

Personal contact 2

Name in full	Relationship to applicant
Address	
Telephone	Mobile
Fax	Email

Compensation or Insurance Claims

19 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.

		Print name	Date
Applicant / Carer signature	✍		
Witness signature	✍		

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 agree to the conditions stated in the Applicant Information Sheet.

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

23 Applicant/Carer signature

	Print name	Date
✍		

Queensland Government | Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB
(including CAEATI Subsidy Funding)
Daily Living Aids and Mobility Equipment

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART B – Prescriber Assessment Complete for MASS/CAEATI funding consideration

Functional Assessment

1 What is the applicant's permanent disability that necessitates assistive equipment?

2 Provide other relevant information including functional changes and/or comorbidities

3 What are the applicant's measurements?

Height **cm** Weight **kg**

4 Describe the applicant's functional status and abilities in the following areas:

A. Physical function

Mobility:

☐ Walks Independently

☐ Walks with Assistance: ☐ Minimum ☐ Moderate ☐ Maximum

☐ Walks with Aid: ☐ Single point stick ☐ wheeled walking aid ☐ other:_____

☐ Manual Wheelchair Self Propelled

☐ Manual Wheelchair Carer assist: ☐ Minimum ☐ Moderate ☐ Maximum

☐ Power Wheelchair

Balance: ☐ Functional ☐ Decreased ☐ Non-Functional

Weight Bearing Status: ☐ Full ☐ Partial ☐ Non

Transfers:

☐ Independent

☐ Independent with aids or set up: ☐ Walker/frame ☐ Slideboard ☐ Grab rails ☐ Other:_____

☐ Assistance: ☐ Minimum ☐ Moderate ☐ Maximum

☐ Dependent

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Functional Assessment continued

Transfer Method: ☐ Slide/side ☐ Stand/pivot ☐ Step ☐ Upper limb weight bearing ☐ Hoist

☐ Other_____

Provide additional information specific to endurance/frequency if relevant:

Upper limb function:

☐ Decreased Strength: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

☐ Decreased range of movement: ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand

☐ Tone: ☐ Low ☐ High ☐ Spasms ☐ Fluctuating

☐ Hand Function: ☐ Functional ☐ Decreased ☐ Non-functional

Lower limb function:

☐ Decreased Strength: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

☐ Decreased range of movement: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

☐ Tone: ☐ Low ☐ High ☐ Spasms ☐ Fluctuating

Postural control in sitting: ☐ Full ☐ Limited ☐ Nil Functional

Skeletal deformity: ☐ Scoliosis ☐ Kyphosis ☐ Pelvic Tilt ☐ Pelvic Rotation ☐ Pelvic Obliquity

☐ Upper Limb ☐ Lower Limb ☐ Other _____

5 Describe the applicant's living situation (e.g. lives alone, receives carer support etc):

☐ Alone ☐ Alone with informal support ☐ Alone with formal support ☐ With Family/Carer

☐ Other _____

Queensland Government | Medical Aids Subsidy Scheme (MASS) Queensland Health

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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART C – Equipment Application Complete for MASS funding consideration

Use this form to apply for

- **multiple items for an individual or**
- **any single item excluding wheeled walking aid, equipment modification, Static or 3-in1 commode, bath transfer bench, non-standard bathboard or similar purpose device**
- **CAEATI - Complete sections A, B & D only**

1. If applying for modifications to an existing MASS item on permanent loan use Daily Living Aids and Mobility Equipment Letter Template.
2. If replacing a current MASS item with the same item i.e. like with like - replacing same size, brand and model of sling, use Daily Living Aids and Mobility Equipment Letter Template.
3. If applying for a Static or 3-in1 Commode, Bath Transfer Bench / Swivel Bathseat / Bath Lift or similar purpose device or non-standard Bathboard only use the MASS 20 BTA application form – Static 3-in1 Commode, Transfer Bench/Swivel Bathseat/Bath lift or similar purpose device, non-standard bathboard
4. If applying only for a Wheeled Walking Aid through

- MASS - use the MASS 20 WWA - Wheeled Walking Aid Application form
- CAEATI - use this form MASS 20 DLA/MOB - Sections A, B & D only.

Current versions of all documents can be found on the MASS website: http://www.health.qld.gov.au/mass

Equipment – Request

1 Item/s requested:

- ☐ Static or 3-in-1 Commode
- ☐ Bath Transfer Bench / Swivel Bathseat / Bath Hoist or non-standard Bathboard, or similar purpose device
- ☐ Mobile Shower Commode (MSC) or Shower Trolley
- ☐ Patient Lifting Device (Hoist) and Sling or Patient Transfer Platform
- ☐ Pressure Redistribution Mattress/Overlay or Sleep Positioning System
- ☐ Wheeled Walking Aid (WWA)
- ☐ Manual Wheelchair (MWC)
- ☐ Tilt-in-Space Manual Wheelchair (including specialised stroller)
- ☐ Power Wheelchair (PWC)
- ☐ Pressure Redistribution Cushion
- ☐ Back up manual wheelchair
- ☐ Modifications to existing equipment. Please list item/s requiring modifications

2 Is this equipment required for discharge from hospital, transition care or post-acute services? ◯ Yes ◯ No

3 a) Has the applicant had one or more falls in the last month? ◯ Yes ◯ No
b) Is the aim of the requested item to prevent future falls? ◯ Yes ◯ No

4 a) Does the applicant have a current pressure injury? ◯ Yes ◯ No
b) Is the aim of the requested item to manage a current pressure injury? ◯ Yes ◯ No

Queensland Government

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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Reason for this Application

5 Why does the current equipment need replacing?

☐ Not Applicable ☐ No longer meets client needs ☐ MASS Requested Replacement ☐ Beyond Economic Repair

(Provide reason) (Describe condition of equipment)

Equipment Trials and Justification

6 All item/s trialled

Model / Type / Size	Length and location of trial	Outcome of trial / comments

7 Item/s selected: provide details of requested equipment including cushion if applicable.

Model / Type / Size	Trial supplier

8 Does your client require Tilt in Space? ◯ Yes ◯ No

If **yes**, select all that apply.

- ☐ Facilitate repositioning, transfers, and weight shift during the operation of the Power Wheelchair
- ☐ Achieve or maintain a suitable posture
- ☐ Redistribute pressure so less pressure is directed through bony prominences on the seat
- ☐ Better manage gastrointestinal function
- ☐ Better manage respiration
- ☐ Facilitate optimal positioning for comfort and function due to deformity/pain/involuntary movement/ abnormal tone/seizure activity
- ☐ Facilitate hoist transfers
- ☐ Facilitate the client's negotiation over uneven surfaces, kerbs, ramps etc.
- ☐ Facilitate the client's operation of a powered wheelchair

For Daily Living Aids or MASS only funded Mobility Aids, provide justification for modification/accessories if applicable below.
For Mobility Aids requesting a combination of MASS and CAEATI funding, skip question 9 and go to PART D CAEATI Q7 to complete all clinical justification for modifications/accessories.

9 **Modification/Accessory**
(as listed on supplier's quote)
Clinical justification to support MASS funding

10 Has the prescribed equipment been successfully trialled in the home environment? ◯ Yes ◯ No

If **no**, describe how you have determined the equipment will be suitable for the applicant at home.

11 Can the prescribed equipment be appropriately used, maintained and stored by the applicant or carer? ◯ Yes ◯ No

12 Has a safety switch/residual current device been installed for items connected to mains power for operating/charging? ◯ Yes ◯ No ◯ N/A

13 Is the equipment requested on the MASS SOA Product List?

◯ Yes

◯ No, explain why a non-SOA item has been requested.

Queensland Government

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Equipment Prescription

For ALL MASS applications complete questions 14-20

If applying for **Pressure Redistribution Equipment** go to **Q 14**
If applying for **Non-Basic Pressure Redistribution Mattress** go to **Q15**
If applying for **Sleep Positioning System** go to **Q 16**
If applying for a **Patient Transfer Platform** go to **Q 17**
If applying for a **Hoist and Sling** go to **Q 18**
If applying for a **Sling and Attachment** go to **Q 19**
If applying for a **Bathing and Toileting Aids** go to **Q 20**
If applying for **Mobility Aids (Wheelchair or Wheeled Walking Aid)** go to **Q 21**

For **Pressure Redistribution Equipment**

14 (a) Please select one or more of the following which apply:

- ☐ At risk of developing a pressure injury as identified through a formal risk screening tool
- ☐ Unable to effectively redistribute pressure
- ☐ History of pressure injury
- ☐ Major fixed skeletal deformity and/or motor/sensory loss with potential for pressure injury development
- ☐ Confined to bed for prolonged periods of time and is at risk of developing pressure injury.

(b) Have skin checks been completed to confirm suitability? ☐ Yes ☐ No

If **no**, describe why skin checks were not completed.

For **Non-Basic Pressure Redistribution Mattress**

15 (a) Does the applicant have a significant history of pressure injury? ☐ Yes ☐ No

If **yes**, provide details:

(b) Does the applicant have severe restriction in mobility? ☐ Yes ☐ No

If **yes**, provide details:

(c) Has an extensive range of basic pressure redistribution mattresses been trialled/considered? ☐ Yes ☐ No

If **yes**, provide details:

For **Sleep Positioning Systems**

16 Does the applicant require support and positioning in lying to facilitate (please select all that apply):

- ☐ Improved respiration and/or swallowing
- ☐ Prevention of pressure injury through specific positioning needs
- ☐ Improved positioning for prevention of contractures and/or deformities

Current Equipment, Trial Outcomes and Justification continued

For a **Patient Transfer Platform**

17 (a) Can the applicant effectively reposition their feet to complete a pivot or similar transfer? ◯ Yes ◯ No

(b) Does the device requested provide adequate support to allow the applicant to stand? ◯ Yes ◯ No

(c) Is the applicant able to adequately stand with the support provided by the device? ◯ Yes ◯ No

For **a Hoist**

18 (a) For a **Standing Hoist**

Does the applicant require mechanical assistance to stand? ◯ Yes ◯ No

Does the applicant demonstrate reliable ability to assist with the standing action being facilitated by the hoist? ◯ Yes ◯ No

b) For a **Mobile Floor Hoist**

Can the applicant effectively complete a standing or non-standing transfer with assistance or a device such as a slide board? ◯ Yes ◯ No

Does the applicant require a non-basic hoist for increased lift height, leg spread or boom length? ◯ Yes ◯ No

If **yes**, provide details

c) For a **Ceiling Hoist**

Can the applicant effectively complete a standing or non-standing transfer with assistance or a device such as a slide board? ◯ Yes ◯ No

Have you completed and attached the MASS Ceiling Hoist Checklist? ◯ Yes ◯ No

d) For a **Multilift Hoist**

Can the applicant effectively complete a standing or non-standing transfer with assistance or a device such as a slide board? ◯ Yes ◯ No

Nb: one or more of the following criteria must apply
Does the applicant require support both standing and full lift for different transfer purposes? ◯ Yes ◯ No

Is the applicant able to complete stand transfer with assistance of a standing hoist but will experience predicted decline in function? ◯ Yes ◯ No

Does the applicant's needs fluctuate between transfer methods? ◯ Yes ◯ No

Has the full lift component of the multilift hoist been considered for current and likely future needs? ◯ Yes ◯ No

For a **Sling and Attachment**

19 e) Is the prescribed **mobile floor hoist, standing hoist, multilift or ceiling hoist** compatible with the prescribed sling? ◯ Yes ◯ No

If no, please complete and submit MASS Hoist and Sling Compatibility Checklist

Is the basic hoist attachment (standard spreader bar) suitable? ◯ Yes ◯ No

If **no**, specify attachment and provide justification ☐ 4 Point ☐ Pivot ☐ Other_____

Queensland Government Medical Aids Subsidy Scheme (MASS) Queensland Health

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Daily Living Aids and Mobility Equipment

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Current Equipment, Trial Outcomes and Justification continued

For **Bathing and Toileting Aids**

20 (a) Can the applicant effectively walk and/or transfer to the toilet and/or shower in the home? ◯ Yes ◯ No

Can the applicant walk or transfer to a static commode? ◯ Yes ◯ No

(b) For a **Mobile Shower Commode/Shower Trolley**

Is there sufficient space in the bathroom or wet area for a mobile shower commode/ shower trolley including over toilet access if applicable? ◯ Yes ◯ No

Can the applicant or carer propel the chair/trolley, including changes in floor level? ◯ Yes ◯ No

(c) For a **Mobile Shower Commode with Height Modified Frame**

Have adjustable height mobile shower commodes been trialled/considered and found unsuitable? ◯ Yes ◯ No

Provide details:

For **Mobility Aids**

21 (a) Can the applicant independently or effectively use an aid to walk within the home environment? ◯ Yes ◯ No

(b) For a **Manual Wheelchair**

Is a wheelchair required to provide the primary means of functional mobility in the home environment? ◯ Yes ◯ No

Is the applicant a long duration independent user? ◯ Yes ◯ No

Does the applicant require a non-standard size and/or options to meet their positioning and postural needs? ◯ Yes ◯ No

For the Non-Basic MWC Subsidy, what are the needs that cannot be met in a basic MWC Subsidy?

(c) For a **Power Wheelchair**

Have you completed and attached the Home Access Checklist? ◯ Yes ◯ No

Can the applicant self-propel a manual wheelchair effectively in their home environment? ◯ Yes ◯ No

Can the applicant effectively control and manoeuvre the requested PWC inside the home and around any other areas to be accessed by the applicant? ◯ Yes ◯ No

If no, during the assessment have they demonstrated the ability to acquire skills to effectively operate the power wheelchair? ◯ Yes ◯ No

Have you considered your clients's hearing, vision, cognition and ability to control the chair? ◯ Yes ◯ No

Provide details:

(d) For a **Specialised Stroller**

Is the applicant under 5 years of age? ◯ Yes ◯ No

Provide details why the child is unable to be effectively positioned in a non-specialised stroller or use a manual or powered wheelchair

Queensland Government | Medical Aids Subsidy Scheme (MASS) Queensland Health

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(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 MASS applications

First prescriber

22 Name

Title	Family name
Given name(s)	

23 Profession

24 Current registration? ◯ Yes ◯ No

25 Organisation name

26 Organisation address

Suburb / town	Postcode

27 Contact details

Telephone	Fax
Mobile	
Email	

28 Contact hours

29 Signature
I certify that this information is in accordance with the *MASS General Guidelines*.

Date

Second prescriber (if applicable)

30 Name

Title	Family name
Given name(s)	

31 Profession

32 Current registration? ◯ Yes ◯ No

33 Contact details

Telephone	Fax
Mobile	
Email	

34 Contact hours

35 Please list equipment you have prescribed

36 Signature
I certify that this information is in accordance with the *MASS General Guidelines*.

Date

Prescriber Checklist

Have you:

- ☐ retained a copy of the full application for your reference?
- ☐ provided a signed *MASS 84 Proxy Access to Centrelink Information* form or photocopy of both sides of the applicant's concession card?
- ☐ provided an accurate quote/s, accurate specification form (where relevant) and full clinical justification for the prescribed equipment?
- ☐ provided additional supporting documentation if required e.g. hoist and sling compatibility checklist and/or pressure risk assessment?
- ☐ provided a Home Access Checklist for the prescribed power wheelchair?

Queensland Government

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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART D – CAEATI Complete for CAEATI funding consideration

Have you been assessed with Department of Communities, Child Safety and Disability Services (DCCSDS) for eligibility through CAEATI? ☐ Yes, please provide your DCCSDS reference number (BIS number) _____

☐ No, please contact your local DCCSDS Office for assessment

Prescriber Clinical Assessment

1 Please outline the applicant's disability and the impact this has on the applicant's community participation:

2 What category of equipment is being requested?

☐ Active Participation ☐ Community Mobility

☐ Postural Support ☐ Prescriber assessment

(Please refer to the guidelines document for information on CAEATI Prescriber Categories)

3 Item/s trialled for CAEATI funding.

Model / Type / Size	Length and location of trial	Outcome of trial / comments

4 For **CAEATI** only applications for Mobility Aids, Pressure Redistribution Cushions and modifications to MASS owned equipment, please explain why MASS funding hasn't been utilised:

5 Item/s selected for **CAEATI** only applications: provide details of requested equipment.

Model / Type / Size	Trial supplier

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB
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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

6 For modifications/accessories or power assist devices, provide details of the equipment to which the CAEATI items will be attached.

Name and Model _____

MASS Plaque number if applicable: _____

7 **For MASS/CAEATI applications or Modifications/or accessories to existing MASS funded equipment. As per the Guidelines**: CAEATI funds cannot be used for items funded by other government funding bodies, including gap payments. CAEATI funds can only be used for the "frame upgrade" and modification/ accesssories of a MASS wheelchair to enhance the use of the equipment in the community.

Referring to the supplier's quote, in the table below, please list every item listed on the quote and specify if the requested item is being applied for through MASS subsidy funding or CAEATI.

Item to be supplied	To be funded by MASS	To be funded by CAEATI	Justification	CAEATI Amount
FRAME Upgrade		(upgrade only) ☐		$
	☐	☐		$
	☐	☐		$
	☐	☐		$
	☐	☐		$
	☐	☐		$
	☐	☐		$
	☐	☐		$
TOTAL				$

8 **Outcome of successful equipment/additional comments**

Queensland Government | Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB
(including CAEATI Subsidy Funding)
Daily Living Aids and Mobility Equipment

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

9 Provide details of how the successful equipment will improve the applicant's community participation.

10 Is the recommended equipment compatible with the client's transport? ☐ Yes ☐ No

Is the recommended equipment compatible with the client's environment (including storage) ☐ Yes ☐ No

Is the client and/or carers capable of providing maintenance, care and trouble shooting? ☐ Yes ☐ No

Applicant Declaration

☐ I declare that all the information I have supplied on this application is true and correct to the best of my knowledge.

☐ I agree to enquiries being made by MASS and the liaison with other agencies and services for the purpose of obtaining information to best meet my needs and for the purposes of eligibility and assessment for the requested equipment and/or service.

☐ I agree to the use and disclosure of my personal information, provided that it is necessary and relevant for the purpose of assisting me with the provision of equipment and/or service.

Prescriber Subsidy

CAEATI Prescriber Subsidy Funding covers the cost of a registered therapist to assist the applicant in completing the full CAEATI application process. Please be aware that once an eligible applicant's funding limit has been reached, any outstanding prescriber cost will require payment by the applicant.

I am aware $_____ of Prescriber Subsidy Funding is being claimed by the Prescriber for this application?

☐ Yes ☐ No

Applicant Signature

Date

Prescriber Details - Ensure you are a Registered CAEATI Prescriber

Name		Organisation			
Profession		Phone Number		Email	
Address					

Do you wish to apply for CAEATI Prescriber Subsidy Funding for services rendered to this client?

**subject to available subsidy limits for applicant* ☐ Yes ☐ No

Please submit a quote with application. This will be paid upon subsidy approval and receipt of signed CAEATI acquittal form and prescriber invoice.

Prescriber Checklist

Have you:

☐ retained a copy of the full application for your reference?

☐ provided an accurate quote/s and full clinical justification for the prescribed equipment?

Prescriber Declaration

☐ I certify that the information contained in this application is in accordance with the CAEATI Guidelines.

☐ I certify the applicant has been made aware that payment of the Prescriber Subsidy Funding (subject to available subsidy limits) has been requested for services and consultations regarding this application (if applicable).

Prescriber Signature

Date