

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.gld.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.
- 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.
- 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.

MASS20 v3.01 - 11/2015 Page 1 of 2

- 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.
- 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:

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

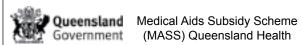
Please send completed form via post or email to:

Medical Aids Subsidy Scheme, Brisbane PO Box 281, Cannon Hill Qld 4170 Telephone: 3136 3524 Fax: 3136 3525

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

MASS20 v3.01 - 11/2015 Page 2 of 2



MASS 20 DLA/MOB (including CAFATI Subsidy Funding)

(Affix identification label her	re if available)
Family name:	
Given name(s):	
Date of birth:	Sex: M F I

Daily Living Aids and		ven name(s):					
		of birth: Sex: M F			M F I		
P	ART A – Applicant Details Co	mplete fo	r M <i>A</i>	ASS/CAE/	ATI funding o	considera	ation
A	pplicant's Personal Details						
1	Name Title Family name Given name(s)			Commonwo Enter ACFI So ADL	cant a resider ealth funded o core of L (Low), N Behaviour	care facilit (Medium) o	or H (High) for: x Care
	Preferred name First name <i>or</i> specify				pplicant recei 3' Affairs bene		rtment Yes
	MASS reference number (if known) Date of birth Sex Male Female			assistance [*]	pplicant receing (e.g. Dept of Palliative Care	Communit	ties / Yes
4	Permanent residential address Suburb / town Postc	ode		I slander or Torres Strait I Aborigin	cant of Aborigigin? For applicible stander origin, to all trait Islander	ants of both	n Aboriginal and
	Telephone Fax			Country of Australia	Other		
	Mobile		13	_anguage s English	Other	16	
	Email		Ca	rer Inforr	mation		
5	Delivery address ☐ Same as residential	address	14	Name Title Given name(Family name		
	Suburb / town Postc	ode	15	Contact in	formation	Fax	
6	Postal address ☐ Same as residential (for correspondence)	address		Mobile			
	Suburb / town Postc	ode	16	Email Relationsh	nip to applicar	nt .	
-			"	Relations	пр то аррпсат		
7	Is the applicant receiving a Home Care Package? Note: If the applicant will be receiving a Home Care package or CDC High Care Package at hospital discharge you should mark 'Yes'.	Yes No	17	Postal add	lress		
	Level 1 Level 2 Level 3 Level 4			Suburb / tow	n		Postcode



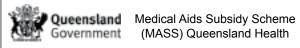
- 10 Sept. et.	
120	Queensland
4600	Government
2505	government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB
(including CAEATI Subsidy Funding)

(Affix identification label here if available)
Family name:
Given name(s):
Date of birth: Sex: M F I

Daily Living Aids and			Given name(s):							
Mobility Equipment			Date of birth:		Sex:	M				
Alt	ter	nate Contac	t Pers	ons						
18	I cc	onsent to MASS	, Queen	ısland Health approa	ching	my pe	rsonal contacts should t	the need ar	ise.	
				` , •			are aware that their na			
		MASS, wno do rsonal Contact		ide with the applica	nt an		will always be aware of onal contact 2	tne applica	nt's address are:	
	_	me in full		Relationship to appli	icant		e in full	Relation	nship to applicant	
	Ad	dress				Addre	ess			
	Те	lephone		Mobile			hone	Mobile	Mobile	
		·								
	Fa	X		Email		Fax		Email		
Co	m	nansation o	r Ineur	ance Claims						
					ron	, othor	form of compensation	or incur	nnoo oloim onnly	
			•		-	•	nd Health is requeste		пісе сіапп арріу	
		Yes, please cor			,					
		No, go to the no	ext secti	on, Service Improve	ment	Activiti	es			
	•	I 🔲 have / 🔲 h	nave not	engaged a legal rep	rese	ntative	to act on my behalf rega	arding a cla	aim for damages.	
	Solicitor's name				Firm's name					
		Firm's address					Suburb		Postcode	
		Telephone		-ax	Email					
						e provid	ded to me by MASS, sh	ould I obta	in damages for	
		-		present or future clai		v alaim	for domogoo. This may	, ha in tha	form of writton	
				S from my legal repr			for damages. This may	be in the	iorm of written	
							rmation to my legal rep	resentative	named above.	
	•	This authority r	emains	valid until revoked by	/ me	in writir	ng.			
	-	plicant /			Print name			Date		
	Ca	rer signature	<u> </u>							
		tness				Print nar	me		Date	
	sig	nature	<u> </u>							
Se	rvi	ce Improver	ment A	ctivities						
20	Ιag	gree to participa	ate in MA	ASS service improve	ment	activiti	es (including internal au	ıdits and sı	ırveys).	
		Yes No								
							MASS Quality System			
					o effe	CT TO SE	ervice provision by MAS	SO IT I WITHO	iraw my consent.	
Αp	pli	icant Acknow	wledge	ement						
				tated in the Applicant						
		cknowledge that plicant/Carer sig		ormation listed in this	appl	ication	is current and correct.			
	11			Pi	rint name		D	ate		



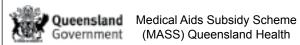
(Affix identification label here if available)

MASS 20 DLA/MOB

(including CAEATI Subsidy Funding)

Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

PA	ART B – Prescriber Assessment Complete for MASS/CAEATI funding consideration
Fu	nctional 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:
	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



MASS 20 DLA/MOB (including CAEATI Subsidy Funding)

(Affix identification label her	e if available)	,	
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

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 Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB

(including CAEATI Subsidy Funding)

Daily Living Aids and **Mobility Equipment**

Family name:	
Given name(s):	
Date of birth:	Sex: M F I

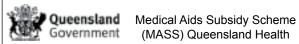
(Affix identification label here if available)

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.

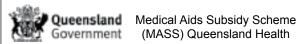
Current versions of all documents can be found on the MASS website: http://www.health.gld.gov.au/mass



MASS 20 DLA/MOB (including CAEATI Subsidy Funding)

(Affix identification label here	if available)	
Family name:		
Given name(s):		
Date of birth:	Sex: MF	

Rea	son for this Application					
5	Why does the current equipment nee	ed replacing?				
	Not Applicable No longer meets of	client needs MASS Requested R	eplacement Beyond Economic Repair			
Г	(Provide reason) (Describe condition of equipment)					
	uipment Trials and Justificati	on				
6	All item/s trialled					
	Model / Type / Size	Length and location of trial	Outcome of trial / comments			
7	Item/s selected: provide details of re		shion if applicable.			
	Model / Type / Size	Trial supplier				



(including CAEATI Subsidy Funding)

(Affix identification label her	re if available)	
Family name:		
Given name(s):		
Date of birth:	Sex: M F	I

8	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 throug	h 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 floist transfers Facilitate the client's negotiation over uneven surfaces, k	erbs, ramps etc.				
	Facilitate the client's operation of a powered wheelchair					
	For Daily Living Aids or MASS only funded Mobility Aids, pro- applicable below.	•				
	For Mobility Aids requesting a combination of MASS and CAID CAEATI Q7 to complete all clinical justification for modification.					
9	9 Modification/Accessory					
	(as listed on supplier's quote) Clinical justification to support MASS funding					
	L					
10	Has the prescribed equipment been successfully trialled in the					
	If no , describe how you have determined the equipment will be suitable for	the applicant at nome.				
4.4	44 Con the proposited equipment be appropriately used projects	inad and atared by the				
11	11 Can the prescribed equipment be appropriately used, mainta applicant or carer?	Yes No				
12	12 Has a safety switch/residual current device been installed for to mains power for operating/charging?	items connected Yes No N/A				
13	13 Is the equipment requested on the MASS SOA Product List? Yes					
	No, explain why a non-SOA item has been requested.					

14866.00	
	Oueensland
不知的	Queensland Government

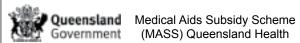
Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 DLA/MOB

(including CAEATI Subsidy Funding)

(Affix identification label her	e if available)		
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

Mobility Equipment	Date of birth:	Sex: M F I
Equipment Prescription		
For ALL MASS applic	cations complete questions 14-20	
If applying for Pressure Redistribution Equipm If applying for Non-Basic Pressure Redistribut If applying for Sleep Positioning System go to If applying for a Patient Transfer Platform go to If applying for a Hoist and Sling go to Q 18 If applying for a Sling and Attachment go to Q If applying for a Bathing and Toileting Aids go If applying for Mobility Aids (Wheelchair or Wh	ion Mattress go to Q15 Q 16 o Q 17 19 to Q 20	
For Pressure Redistribution Equipment		
14 (a) Please select one or more of the following	which apply:	
At risk of developing a pressure injury a Unable to effectively redistribute pressu History of pressure injury Major fixed skeletal deformity and/or mo Confined to bed for prolonged periods o (b) Have skin checks been completed to confir	re otor/sensory loss with potential for press of time and is at risk of developing press	sure injury development
If no , describe why skin checks were not complete		
For Non-Basic Pressure Redistribution Mattres 15 (a) Does the applicant have a significant historif (see a provide details:		☐ Yes ☐ No
(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 position Improved respiration and/or swallowing Prevention of pressure injury through specific specif	ecific positioning needs	all that apply):



(including CAEATI Subsidy Funding)

(Affix identification label her	e if available)		
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

Сι	urrent Equipment, Trial Outcomes and Justification continued	
For	r 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	r 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	r 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 MASS 20 DLA/MOB

(including CAEATI Subsidy Funding)

(Affix identification label he	ere if available	;)	
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

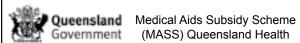
	<u> </u>	
Cu	rrent Equipment, Trial Outcomes and Justification continued	
For	Bathing and Toileting Aids	
20	(a) Can the applicant effectively walk and/or transfer to the toilet and/or shower in the home?	Yes No
	Can the applicant walk or transfer to a static commode?	Yes No
	(b) For a Mobile Shower 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 positioned str	owered wheelchair



(including CAEATI Subsidy Funding)

(Affix identification label he	re if available)
Family name:	
Given name(s):	
Date of birth:	Sex: M F I

T G	Given name(s)	mily name			360	ona pres	criber (if appli	cable)	
Pi	Title Fa	mily name			- 1				
Pi	Given name(s)	mily name			⊣ 30	30 Name			
Pı					∐ 	Title	Family name		
C						Given name(s)			
	3 Profession		_ 3 1	Profession	on				
					╝				
0	urrent regis	stration?	Yes	No	32	Current r	registration?	Yes	No
	rganisation	name			_ 33	Contact	details		
						Telephone		Fax	
0	rganisation	address				Mobile			
						Email			
S	Suburb / town			Postcode	34	Contact	hours		
C	ontact deta	ils							
Т	elephone		Fax			Di !!	-4	• • • • • • • • • • • • • • • • •	
Mobile					35	Please III	st equipment y	ou nave	prescribed
E	Email				1				
C	ontact hou	rs							
					$\rfloor $				
Ιc	ignature certify that this ASS General		is in accord	dance with the	36		e at this information neral Guidelines.	is in acco	ordance with the
			1	Date					Date
2	A]	Ø			
e:	scriber C	hecklist							
	e you:								
_	•	nv of the ful	application	on for your refere	nce?				
_		. •		Access to Centre		nformation	form or photoc	opy of bo	th sides of the
	pplicant's co						1 11111111	17	
	rovided an a		ote/s, accı	urate specification	n form	(where re	elevant) and full	clinical ju	stification for t
] р	rovided add	itional suppo		umentation if req	uired e	e.g. hoist a	and sling compa	tibility ch	ecklist and/or
_ '	ressure risk			for the prescribe	nd nove	or whools	shair?		



(including CAEATI Subsidy Funding)

(Affix identification label her	re if available)	!	
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

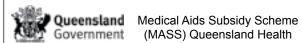
		Bate of Siltin		
PART D - CAEATI Con	nplete for CAE	EATI funding cons	ideration	
Have you been assessed with Deleligibility through CAEATI? Ye	s, please provide		ence number (BIS	S number)
Prescriber Clinical Assessment				
Please outline the applicant participation:	t's disability and	the impact this has	on the applica	nt's community
2 What category of equipmen Active Participation	Co	mmunity Mobility		
Postural Support	Pre	escriber assessment		
(Please refer to the guidelines	s document for in	formation on CAEAT	Prescriber Cate	gories)
3 Item/s trialled for CAEATI fur	•	ad la cation of twick	Outcome of twice	al / commonts
Model / Type / Size	Length at	nd location of trial	Outcome of tria	ii / comments
4 For CAEATI only applications				d modifications to MASS
owned equipment, please exp	plain why MASS	funding hasn't been u	tilised:	
5 Item/s selected for CAEATI or	nly applications:	provide details of requ	uested equipmen	t.
Model / Type / Size	•	Trial supplier		



(including CAEATI Subsidy Funding)

(Affix identification label nei	re ir avallable)		
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	I

For modifications/accessor CAEATI items will be attack Name and Model	ned.		evices, provide details of the equipment to whi	ch the		
MASS Plague number if an	oplicable:					
MASS Plaque number if applicable: 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						
			MASS subsidy funding or CAEATI.	iu specity ii		
Item to be supplied	To be funded by MASS	To be funded by CAEATI	Justification	CAEATI Amount		
FRAME Upgrade		(upgrade only)		\$		
				\$		
				\$		
				\$		
				\$		
				\$		
				\$		
				\$		
TOTAL				\$		
Outcome of successful e	quipment/	additional	comments			



MASS 20 DLA/MOB (including CAEATI Subsidy Funding)

(Affix identification label he	re if available))	
Family name:			
Given name(s):			
Date of birth:	Sex: M	F	

9	Provide	details of how the	successful equip	ment will impr	ove the applican	t's comm	unity partic	cipation.
10	Is the re	commended equi	pment compatible	with the clien	t's transport?			Yes No
	Is the re	commended equi	pment compatible	with the clien	t's environment	(including	storage)	Yes No
	Is the cli	ent and/or carers	capable of providi	ng maintenan	nce, care and tro	uble shoo	oting?	Yes No
Аp	plicant D	eclaration						
	I declare	that all the informa	ation I have supplie	d on this appl	ication is true and	d correct t	o the best o	of my knowledge.
	obtaining		nade by MASS and t st meet my needs a		_		-	
	•		osure of my persona h the provision of e		•	s necessa	ry and rele	evant for the
Pre	scriber Su	bsidy						
full	CAEATI ap	plication process.	ing covers the cost Please be aware the require payment by	nat once an eli	gible applicant's			
			ber Subsidy Fundin			riber for t	this applica	ation?
		No	,		,		• • • • • • • • • • • • • • • • • • • •	
App	licant Sig	nature						
App		nature					Date	
29			ou are a Register	ed CAEATI Pro	escriber		Date	
29	escriber [ou are a Register	ed CAEATI Pro	escriber Organisation		Date	
Pre	escriber [ed CAEATI Pro		Email	Date	
Pro Nar	escriber [Email	Date	
Pro Nan Pro Add	ne fession dress	Details - Ensure y	Pho escriber Subsidy Fund	ne Number	Organisation		Date	
Pro Nan Pro Add	ne fession dress you wish to	Details - Ensure y apply for CAEATI Pre ailable subsidy limits	Pho escriber Subsidy Fund	ne Number ling for services Yes \(\sum \) No	Organisation	ent?		d prescriber invoice.
Pro Nan Pro Addo Do *su Plea	ne fession dress you wish to	Details - Ensure y apply for CAEATI Preside subsidy limits quote with application	Pho escriber Subsidy Fund for applicant	ne Number ling for services Yes \(\sum \) No	Organisation	ent?		d prescriber invoice.
Pro Nan Pro Add Do *su Plea Pro Hav	ne fession fress you wish to bject to ave use submit a escriber (Details - Ensure y apply for CAEATI Presidable subsidy limits quote with application Checklist	Phoescriber Subsidy Func for applicant ''	ne Number ling for services Yes \(\text{No}\) No subsidy approval	Organisation	ent?		d prescriber invoice.
Pro Nan Pro Add Do *su Plea Pro Hav	retained a	apply for CAEATI Preside the color of the full appropriate the copy of the copy of the full appropriate the copy of the	Phoescriber Subsidy Function for applicant . This will be paid upon oplication for your r	ne Number ling for services Yes \(\subseteq \text{No} \) subsidy approval eference?	Organisation rendered to this cli	ent?	uittal form and	d prescriber invoice.
Pro Nai Pro Add Do *su Plea Pre Hav	rescriber E ress ress resubmit a rescriber (ress retained a rescribed are	petails - Ensure y apply for CAEATI Previlable subsidy limits quote with application checklist a copy of the full application application	Phoescriber Subsidy Func for applicant ''	ne Number ling for services Yes \(\subseteq \text{No} \) subsidy approval eference?	Organisation rendered to this cli	ent?	uittal form and	d prescriber invoice.
Pro Nan Pro Addo Do *su Plea Pro Hav	rescriber Consession escriber Consession escriber Consession retained approvided appr	etails - Ensure y apply for CAEATI Previlable subsidy limits quote with application Checklist a copy of the full application accurate quote	Phoescriber Subsidy Functions for applicant . This will be paid upon oplication for your referenced by and full clinical justices.	ne Number ling for services Yes No subsidy approval eference? ustification for	Organisation rendered to this cli and receipt of signed	ent? CAEATI acqu quipment	uittal form and	
Pro Nam Pro Addo Do *su Plea Pro Hav	rescriber Connection fession fession fress you wish to bject to avoing se submit a rescriber Connection and a rescriber Conne	apply for CAEATI Previous apply for CAEATI Previous guote with application checklist acopy of the full application accurate quote, declaration at the information	Phoescriber Subsidy Function for applicant . This will be paid upon oplication for your r	ne Number ling for services Yes \(\subsidy approval \) eference? ustification for pplication is in	Organisation rendered to this cli and receipt of signed the prescribed e	ent? CAEATI acqu quipment	uittal form and	nes.
Pro Nan Pro Addo Do *su Plea Pro Have Pro	retained a provided a certify th	apply for CAEATI Preside by apply for CAEATI Preside by application copy of the full application at the information at the information as policant has be	Phoescriber Subsidy Function of for applicant . This will be paid upon oplication for your rows and full clinical justices on tained in this a	ne Number ling for services Yes No subsidy approval eference? ustification for pplication is in	organisation rendered to this cli and receipt of signed the prescribed e	ent? CAEATI acqui quipment in the CAEA	uittal form and	nes. ct to available
Pro Nam Pro Addo Do *su Plea Pro Hav	rescriber I ress you wish to bject to avoise submit a rescriber I retained a provided a rescriber I certify the subsidy li	apply for CAEATI Preside by apply for CAEATI Preside by application copy of the full application at the information at the information as policant has be	Phoescriber Subsidy Functions for applicant . This will be paid upon opplication for your rows and full clinical justices and full clinical justices and full application for your rows and full clinical justices	ne Number ling for services Yes No subsidy approval eference? ustification for pplication is in at payment of to and consulta	organisation rendered to this cli and receipt of signed the prescribed e	ent? CAEATI acqui quipment in the CAEA	uittal form and	nes. ct to available
Pro Nam Pro Addo Do *su Plea Pro Hav	rescriber I ress you wish to bject to avoise submit a rescriber I retained a provided a rescriber I certify the subsidy li	apply for CAEATI Previous guote with application copy of the full application at the information e applicant has been requited.	Phoescriber Subsidy Functions for applicant . This will be paid upon opplication for your rows and full clinical justices and full clinical justices and full application for your rows and full clinical justices	ne Number ling for services Yes No subsidy approval eference? ustification for pplication is in	organisation rendered to this cli and receipt of signed the prescribed e	ent? CAEATI acqui quipment in the CAEA	uittal form and	nes. ct to available