#### Medical Aids Subsidy Scheme (MASS), Queensland Health



# Applicant Information Sheet for MASS 20 WWA

### **Application for Wheeled Walking Aid**

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/)

#### **How to Apply**

Applicants wishing to apply to MASS for Daily Living Aids and/or Mobility Equipment must consult an Occupational Therapist (OT), a Physiotherapist (PT), Rehabilitation Engineer (RE) or a Registered Nurse for rural and remote areas only, in conjunction with an OT or PT. They will provide an assessment of your needs and assist you to choose the most appropriate equipment. You are required to sign **PART A** and your prescribing therapist is required to complete and sign **PART B**.

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

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

MASS20 v2.05 - 01/2017 Page 1 of 2

#### I agree to:

- Having photographs/video footage taken to assist with my application (for power wheelchairs, optional for other aids). 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.
- 14 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.
- **15** 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:

- 17 repairs and maintenance become my responsibility.
- **18** insurance cover becomes my responsibility.

#### **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.gld.gov.au

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 v2.05- 01/2017 Page 2 of 2



Queensland Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 WWA Wheeled Walking Aid

(Affix identification label here if available)

Family name:

Given name(s):

				` '					
			Date of bir	th:			Sex:	М	F I
P	ART A – Applicant Details To	be c	omplete	d by the a	pplicar	ıt / ca	rer		
A	pplicant's Personal Details								
1	Name  Title Family name  Given name(s)  Preferred name First name or specify		8	Note: If the ap	realth further by Low policant is	acility na	care facili ame		Yes No
			9	Does the a	pplican	t recei		artmei	
2	MASS reference number (if known)		10	of Veterans  Does the a assistance	pplican	t recei	ve other	ities /	No Yes
3	Date of birth Sex Male Female			Disabilities, If yes, name					
4	Permanent residential address		_   11	Is the appl Islander or Torres Strait Aborigin	<b>rigin?</b> Fo Islander nal	or applio origin, t	cants of bot	h Abor	iginal and
	Suburb / town Poste	code	12	Torres S  Country of	Strait Isla <b>f birth</b>	ınder	Yes	No	
	Telephone Fax			Australia					
	Mobile			Language English	Othe		ne		
	Email			rer Infor	mation				
5	<b>Delivery address</b> ☐ Same as residentia	l addre	ess 14	Name Title	Family na	ıme			
				Given name(	(s)				
	Suburb / town Post	code	15	Contact in	formatio	on			
6	Postal address Same as residentia (for correspondence)	l addre	ess	Telephone Mobile			Fax		
				Email					
	Suburb / town Post	code	16	Relationsh	nip to ap	plican	t		
7	- · · · · · · · · · · · · · · · · · · ·	• _							
	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 17	Postal add	Iress				
	Level 1 Level 2 Level 3 Level 3	4		Suburb / tow	'n			Postco	ode



No.	Queensland Government		Subsidy Scheme			(Affix identification labe	I here if a	available)
NAA	— ASS 20 WWA			Fan	nily name	e:		
	neeled Walking	-		Give	Address  Telephone Mobile  Fax Email  To the form of compensation or insurance claim apply trueensland Health is requested?  Int Activities  The firm's name Suburb Postcode  The provided to me by MASS, should I obtain damages for the form of written entative.  The provided information to my legal representative named above.			
				Date	e of birth	:	Sex	c: □M □F □I
	ernate Contac							
	The names and a	ddresses of not reside	two (2) personal	conta	icts who	are aware that their nawill always be aware of	ames ha	ave been provided
	Name in full		Relationship to appl	icant			Re	lationship to applicant
Address				Addre	ess			
	Telephone	Mo	bbile		Telep	hone	Mobile	
	Fax	En	nail		Fax		Email	
Со	mpensation o	r Insuran	ce Claims					
								surance claim apply
	Yes, please co			5, QI	ieensia	nd Health is requeste	ea r	
			Service Improve					
	I have / I  Solicitor's name	have not en	gaged a legal rep	orese	ntative t	, ,	arding a	a claim for damages.
	Solicitor's Harrie					Timis name		
	Firm's address					Suburb		Postcode
	Telephone	Fax		Emai				
	<ul><li>injuries from ar</li><li>I undertake to a communication</li><li>I provide autho</li></ul>	ny past, pre advise MAS n to MASS f prity for MAS	sent or future cla SS of the progress rom my legal rep	im/s. s of m reser prov	ny claim Itative. ide infoi	for damages. This ma	y be in t	the form of written
	Applicant / Carer signature	Za.			Print nar	ne		Date
	Witness signature	Za .			Print nar	ne		Date
Se	rvice Improve	ments						

20	I agree to participate in MASS service improvement activity	ities (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
<b>D</b>		

(Affix identification label here if available)

MASS 20 WWA
Wheeled Walking Aid

Given name(s):

Family name:

Date of birth:

M	F	

# **PART B – Equipment Application**

To be completed by the prescriber in accordance with MASS Application Guidelines for Mobility Aids

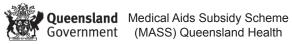
#### Use this form to apply for:

- 1. Wheeled Walking Aids on the MASS SOA list.
- 2. Non-SOA Wheeled Walking Aids, with the provision of additional clinical justification and quote.

NB: If you are applying for a Wheeled Walking Aid together with other equipment or for equipment through CAEATI funding, use the MASS 20 DLA/Mob Application Form.

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

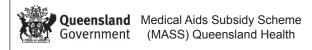
Equipment – Request
1 Item requested: MASS SOA Wheeled Walking Aid Non-SOA Wheeled Walking Aid
2 a) Is the Wheeled Walking Aid required for discharge from hospital, transition care or post acute services?
b) Have you confirmed that the prescribed equipment is available from the supplier?
3 a) Has the applicant had one or more falls in the last month?  b) Is the aim of the requested item to prevent future falls?  Yes I
Functional Assessment
4 Applicant's permanent disability that necessitates the requested aid:
5 Provide other relevant information, functional changes and or comorbidities
The state of the s
6 What are the applicant's measurements?
Height cm Weight kg
7 Is the Wheeled Walking Aid required to provide the primary means of functional mobility in the home
environment
☐ Yes ☐ No
8 The Wheeled Walking Aid is required for the following reasons
Falls Risk Reduced walking endurance
☐ Decreased lower limb strength ☐ Pain ☐ Decreased balance (dynamic standing) ☐ Other (describe below or attach an additional page
Please describe:



**Current Equipment** 

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

9	Current equipment requiring	g replacement (if applicable)		
	Model:			Age:
		_	SS Requested Replacement [	Beyond Economic Repair (Describe condition of equipment)
Eq	uipment Trial			
10	Wheeled Walking Aid trialle Model / Type / Size		on of trial Results	comments
W	neeled Walking Aid Pr	escription - SOA Item		
11		•	nments and/or modifications	S.
	Trial Supplier :			
	Supplier	Product Type	Product Name/Code	Safe Working Load (KG)
	Active Medical	Forearm Support Walker	Unilite 6742	100
	Active Medical	Forearm Support Walker	Unilite Wide 6746	100
	Active Medical	meets client needs MASS Requested Replacement Beyond Economic Repair (Describe condition of equipment)  with client.  Length and location of trial Results / comments  scription - SOA Item quired for WWA with attachments and/or modifications.  Product Type Product Name/Code Safe Working Load (KG)  Forearm Support Walker Unilite 6742 100  Forearm Support Walker Unilite Wide 6746 100  Forearm Support Walker Router Comfort 150  Forearm Support Walker Router Comfort 150  Forearm Support Walker Server HD 200  Forearm Support Walker TiAMA Small C4501G 150  Forearm Support Walker TiAMA Small C4500G 150  Forearm Support Walker BRO213 Steel 130  Forearm Support Walker BRO213 Steel 130  Forearm Support Walker BRO213 Steel 120		
	Active Medical	Forearm Support Walker		150
	Active Medical	Forearm Support Walker		200
	Aidacare	Forearm Support Walker		180
	Country Care Group	Forearm Support Walker		150
	Country Care Group	Forearm Support Walker		150
	Freedom Healthcare	Forearm Support Walker		130
	Walk on Wheels	Forearm Support Walker		120
	Country Care Group	Paediatric Walker		68

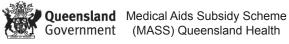


(Affix identification label here if available)

# MASS 20 WWA Wheeled Walking Aid

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

Supplier	Product Type	Product Name/Code	Safe Working Load (KG)
Country Care Group	Paediatric Walker	Rifton Pacer Large	90
Country Care Group	Paediatric Walker	Rifton Pacer X-Large	124
Mobility Plus	Paediatric Walker	Malte 3500100	20-100
Mobility Plus	Paediatric Walker	Malte 7501100 Outdoor 1	30
Mobility Plus	Paediatric Walker	Malte 7502100 Outdoor 2	50
Mobility Plus	Paediatric Walker	Malte 7503100 Outdoor 3	70
Mobility Plus	Paediatric Walker	Marcy Anterior Walker Size 2 adjustable base	50
Mobility Plus	Paediatric Walker	i	50
R82	Paediatric Walker	Crocodile 86801	30-80
R82	Paediatric Walker	Mustang 869041	30-80
Aidacare	Adult/Push down brakes	WAF705600 - 7" wheels	130
Medistore	Adult/Push down brakes	MARL8149	130
Active Medical	Adult	Grande Seat Walker 6861	200
Aidacare	Adult	WAF750020 X L Bariatric	180
Aidacare	Adult	WAF705700 Classic	130
Aidacare	Adult	WAF705800 Mini	130
Aidacare	Adult	Aspire Classic 6" wheels	130
Aidacare	Adult	Aspire Deluxe Seat Walker	130
Country Care Group	Adult	Active Walker	125
Country Care Group	Adult	Easy way Ultra Light HD 66108B	180
Country Care Group	Adult	Easy way Ultra Light 66108	140
Country Care Group	Adult	Ellipse 6 Petite 8217	150
Country Care Group	Adult/Weight	Ellipse 6 (Push down brakes)	150
Country Care Group	Adult	Ellipse 6 8156	150
Country Care Group	Adult	Ellipse 8 8187	150
Country Care Group	Adult	Ellipse 8 Tall 8224	150
Country Care Group	Adult	Ellipse XSMALL 66118	100



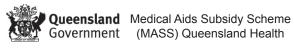
(Affix identification label here if available)

Family name:

Given name(s):

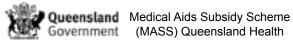
Date of birth: Sex: M

Supplier	Product Type	Product Name/Code	Safe Work Load (KG)
Country Care Group Adult		Ellipse Lite	135
Country Care Group	Adult	Ellipse Superlite	120
Country Care Group	Adult	☐ Mack Walker C4205-CG	225
Country Care Group	Adult	☐ Mighty Mack C4216-B	225
Country Care Group	Adult	Mini Mack C4205-C	225
Country Care Group	Adult	☐ TiAMA Small C4501	150
Country Care Group	Adult	☐ TiAMA Tall C4500	150
Elan Medical	Adult	High Mack HD NOV-AC34H	150
Elan Medical	Adult	Low Mack HD NOV-AC34L	150
Elan Medical	Adult	Supa Mack HD NOV-MOBWAL70116	225
Elan Medical	Adult	Low Seat 8" Wheels MFI-V4606 18INCH	125
Elan Medical	Adult	MFI-V4208 6" Wheels	100
Elan Medical	Adult	MFI-V4206 22INCH 8" Wheels	125
Elan Medical	Adult	Alpha 426 Rollator (Blue)	125
Elan Medical	Adult	Alpha 427 Rollator (Blue)	125
Elan Medical	Adult	Alpha 419 Rollator (Silver)	125
Elan Medical	Adult	☐ ErgoPrimo Posterior Walker	125
Freedom Healthcare	Adult	BRO204 X-Short Y-Standard Z-Tall	200
Freedom Healthcare	Adult	BRO209 - Extra Wide Heavy Duty	200
Freedom Healthcare	Adult	BRO210 - Heavy Duty - Steel	130
Freedom Healthcare	Adult	□ BRO200	130
Freedom Healthcare	Adult	☐ BRO202	130
Freedom Healthcare	Adult	BRO202High Seat X-50cm Y-55cm Z-59cm	140
Freedom Healthcare	Adult	BRO201 Adjust Seat - 6" wheels	130
Freedom Healthcare	Adult	BRO201-Z Adjust Seat - 8" wheels	130
K Care Healthcare	Adult	KA365R Seat Walker	120
K Care Healthcare	Adult	KA365/7RE Seat Walker	120
K Care Healthcare	Adult	KA365M Maxi Seat Walker	225
K Care Healthcare	Adult	KA365S Seat Walker	120
Medistore	Adult	Euro Lightweight Wheeled Walker	136
Medistore	Adult	MARL8187 All Terrain	130



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

	Date of birth:	Sex: M F I						
Adult AM-M	3-040 Budget	130						
Adult								
Adult -								
Adult -								
Adult -								
Adult								
Adult								
·								
A item has been reques	sted:							
Indicate model, supplier and trial supplier of non SOA Wheeled Walking Aid required.								
	Supplier	Trial supplier						
Trial Outcomes and Justification								
13 Has the prescribed wheeled walking aid been trialled in the home environment? Yes No								
<u>-</u>								
14 Will the prescibed equipment be compatible with and manoeuvrable inside the applicant's home (e.g. fit through doorways, negotiate changes in levels)								
	Adult	Adult						



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

Proscribor Dotails to be complete	ad in full for all ann	dicat	ions				
Prescriber Details to be completed in full for all applications  First prescriber  Second prescriber (if applicable)							
First prescriber 15 Name		_	Name	criber (ii applic	Sable)		
Title Family name		23	Title	Family name			
				-			
Given name(s)			Given name(s)				
16 Profession		24	Professio	n			
17 Current registration? Yes	No	25	Current re	egistration?	Yes	No	
18 Organisation name	_	26 Contact details					
			Telephone		Fax		
19 Organisation address			Mobile				
			Email				
Suburb / town	Postcode	27	Contact h	ours			
20 Contact details		28 Please list equipment you have prescribed					
Telephone   Fax							
Mobile							
Email							
21 Contact hours							
22 Signature I certify that this information is in accordance with the I certify that this information is in accordance with the					ordance with the		
MASS General Guidelines.	ianos mar are			eral Guidelines.			
.	Date		~			Date	
Prescriber Checklist							
Have you:							
checked that the client's weight is w		-	` '				
provided an accurate quote if walker has attachments and/or modifications?							
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?							



# Proxy Access to Centrelink Information Form for MASS 84

This form is used for applicants, 16 years of age and over, to provide consent to MASS staff to access Centrelink concession card information when a photocopy of the concession card is not attached to the MASS application form

Medical Aids Subsidy Scheme (MASS) staff, in accordance with the MASS Privacy Statement, are committed to maintain strict confidentiality in all aspects of service delivery. You are assured that this information will remain confidential. Your information will not be divulged without your consent, or if required or authorised by law. Please provide the following Commonwealth benefit card information, which must be in the name of the adult card holder/applicant. Child applicants will be required to provide a copy of their card. **Concession Card Provider** (please tick): Centrelink Department of Veteran's Affairs **Type of Concession Card** (e.g. Health Care Card): **Applicant's Concession Card Number:** Name of Card Holder: Address on Card: **Issue Date on Card: Expiry Date on Card (if applicable):** This consent will be used for the sole purpose of authorising Centrelink to provide information to MASS to access your eligibility in relation to assistance or services provided by MASS. **Applicant Confirmation:** authorise: The Medical Aids Subsidy Scheme (MASS) to use Centrelink Confirmation eServices to perform a Centrelink or DVA enquiry of my Centrelink or Department of Veterans' Affairs customer details and concession card status to enable the business to determine if I qualify for a concession, rebate or service. the Australian Government Department of Human Services (the department) to provide the results of that enquiry to MASS. I understand that: the department will disclose personal information to MASS including my name/address/payment type/payment status and concession card type and status to confirm my eligibility for assistance and services provided by MASS. this consent, once signed, remains valid while I am a customer of MASS unless I withdraw it by contacting MASS or the department. I can get proof of my circumstances/details from the department and provide it to MASS so my eligibility for assistance and service eligibility can be determined. if I withdraw my consent or do not alternatively provide proof of my circumstances/details, I may not be eligible for the assistance provided by MASS. Signed: Date: Email, Post OR Fax completed forms to a MASS Service Centre **Brisbane:** Townsville: Email: Medical Aids Subsidy Scheme Medical Aids Subsidy Scheme mass184@health.qld.gov.au PO Box 281 PO Box 980 Website: www.health.qld.gov.au/mass



# Telephone: 3136 3636 Fax: 3136 3666 Telephone: 4433 8000 Fax: 4433 8001 OFFICE USE ONLY Details and Eligibility confirmed: Yes No Date: MASS Officer:

Hyde Park Qld 4812

Cannon Hill Qld 4170

MASS84 v3.01 - 03/2017 Page 1 of 1