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.

9 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.

11 could be allocated from existing MASS stock. MASS may choose to reallocate suitable equipment and not purchase new

I agree to:

12 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.
13 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.
16 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.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 WWA

Wheeled Walking Aid

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART A – Applicant Details To be completed by the applicant / carer

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

If *yes*, level ◯ High ◯ Low	Facility name

Note: If the applicant is receiving High Care, they will not be eligible for MASS funding.

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

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Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 WWA

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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 Improvements

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
✍		

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Wheeled Walking Aid

(Affix identification label here if available)

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Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

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? ◯ Yes ◯ No

b) Have you confirmed that the prescribed equipment is available from the supplier? ◯ 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

Functional Assessment

4 Applicant's permanent disability that necessitates the requested aid:

5 Provide other relevant information, functional changes and or comorbidities

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
- ☐ Decreased lower limb strength
- ☐ Decreased balance (dynamic standing)
- ☐ Reduced walking endurance
- ☐ Pain
- ☐ Other (describe below or attach an additional page)

Please describe:

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MASS 20 WWA

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Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Current Equipment

9 Current equipment requiring replacement (if applicable)

Model:	Age:

Why does the current equipment need replacing?

☐ Not Applicable ☐ No longer meets client needs (Provide reason) ☐ MASS Requested Replacement ☐ Beyond Economic Repair (Describe condition of equipment)

Equipment Trial

10 Wheeled Walking Aid trialled with client.

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

Wheeled Walking Aid Prescription - SOA Item

11 Tick one item only. Quote required for WWA with attachments and/or modifications.

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	Forearm Support Walker	☐ Cruiser Petite	175
Active Medical	Forearm Support Walker	☐ Router Comfort	150
Active Medical	Forearm Support Walker	☐ Server HD	200
Aidacare	Forearm Support Walker	☐ BRO212 Heavy Duty	180
Country Care Group	Forearm Support Walker	☐ TiAMA Small C4501G	150
Country Care Group	Forearm Support Walker	☐ TiAMA Tall C4500G	150
Freedom Healthcare	Forearm Support Walker	☐ BRO213 Steel	130
Walk on Wheels	Forearm Support Walker	☐ FL-0366A	120
Country Care Group	Paediatric Walker	☐ Rifton Pacer Medium	68

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Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

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	☐ Marcy Anterior Walker Size 2 non-adjustable base	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

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MASS 20 WWA

Wheeled Walking Aid

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Supplier	Product Type	Product Name/Code	Safe Working 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

Queensland Government 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 birth: Sex: ☐ M ☐ F ☐ I

Medistore	Adult	☐ AM-M3-040 Budget	130
Medistore	Adult	☐ MARL8255 Shopper	130
Medistore	Adult	☐ AM-M3-043 Smooth Glide	130
Walk on Wheels	Adult	☐ Bariatric Maxi FL-0361A	140
Walk on Wheels	Adult	☐ Mini Gopher FL-0253A	110
Walk on Wheels	Adult	☐ FL-0285A	120
Walk on Wheels	Adult	☐ FL-0288A	120

Wheeled Walking Aid - Non SOA Item

12 Explain why a non SOA item has been requested:

Indicate model, supplier and trial supplier of non SOA Wheeled Walking Aid required.

Model	Supplier	Trial supplier

Trial Outcomes and Justification

13 Has the prescribed wheeled walking aid been trialled in the home environment? ◯ Yes ◯ No

If no, describe how you have determined it will be suitable for the applicant's home:

14 Will the prescibed equipment be compatible with and manoeuvrable inside the applicant's home (e.g. fit through doorways, negotiate changes in levels) ◯ Yes ◯ No

If no, provide details:

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Wheeled Walking Aid

(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 applications

First prescriber

15 Name

Title	Family name
Given name(s)	

16 Profession

17 Current registration? ◯ Yes ◯ No

18 Organisation name

19 Organisation address

Suburb / town	Postcode

20 Contact details

Telephone	Fax
Mobile	
Email	

21 Contact hours

22 Signature

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

Date

Second prescriber (if applicable)

23 Name

Title	Family name
Given name(s)	

24 Profession

25 Current registration? ◯ Yes ◯ No

26 Contact details

Telephone	Fax
Mobile	
Email	

27 Contact hours

28 Please list equipment you have prescribed

29 Signature

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

Date

Prescriber Checklist

Have you:

- ☐ checked that the client's weight is within Safe Working Load (SWL) of equipment
- ☐ 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?

Queensland Government

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): Choose one:

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:

I, _____ 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

Email:
mass184@health.qld.gov.au
Website: www.health.qld.gov.au/mass

Brisbane:
Medical Aids Subsidy Scheme
PO Box 281
Cannon Hill Qld 4170
Telephone: 3136 3636 Fax: 3136 3666

Townsville:
Medical Aids Subsidy Scheme
PO Box 980
Hyde Park Qld 4812
Telephone: 4433 8000 Fax: 4433 8001

OFFICE USE ONLY

Details and Eligibility confirmed: ☐ Yes ☐ No

Date: | MASS Officer:

SW8024