Applicant Information Sheet for MASS 50 Continence Aids: Initial and Review Application

The person who will receive the continence aids (applicant) should retain this section for their records.

Eligibility

Administrative eligibility is dependent upon the applicant being a permanent Queensland resident. The applicant must hold one of the following eligibility cards – in the name of the applicant:

- Centrelink Pensioner Concession Card
- 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

Applicant's wishing to apply to MASS for Continence Aids must consult one of the following MASS designated prescribers:

- Continence Specialist Registered Nurse
- Geriatrician
- Occupational Therapist
- Paediatrician
- Physiotherapist
- Registered Nurse
- Urogynaecologist
- Urologist

You are required to sign **PART A** and your prescribing therapist is required to complete and sign **PART B**.

Post OR fax completed applications to a MASS Service Centre

Medical Aids Subsidy Scheme
PO Box 281, Cannon Hill Qld 4170
Telephone: 3136 3665 or 1 300 443 570
Fax: 3136 3666 or 1 300 446 172
Email: mass184@health.qld.gov.au
Website: www.health.qld.gov.au/mass

Applicant Acknowledgement

I confirm that:

1. I have undergone continence assessment, treatment and management prior to this application being submitted to MASS.
2. I have actively participated in the selection of the continence aids and that the requested aids are suitable for my needs.
3. the information provided to the prescriber is accurate and reflects my current health condition.
4. I have been instructed on the use, management and disposal of the prescribed continence aid(s).

I acknowledge that:

5. MASS provides subsidy funding assistance, which is not intended to provide for all my needs.
6. the features and options of the continence aids have been fully explained, as well as possible alternatives that may be available to me through MASS.
7. MASS is unable to exchange requested continence aid(s) once ordered from the supplier.
8. MASS requires one month to process applications. However, if further information is required by MASS regarding the application this processing period may be exceeded.
9. to receive ongoing assistance for continence aids, reapplications are required.
10. I have been advised that my eligibility for ongoing MASS assistance is subject to the outcome of ongoing clinical review by a MASS designated prescriber.

I agree to:

11. 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;
    - admission to high care residential facility etc.

MASS Privacy Statement

YOUR PRIVACY: The Queensland Health, **Medical Aids Subsidy Scheme** (MASS) is collecting 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 the applicant's 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. community care, commercial suppliers 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.

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 50
Continence Aids: Initial and Review Application

This form is used for the initial continence aids application, three yearly review or a change in type of continence aids

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART A 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 Date of birth

Sex ☐ Male ☐ Female

3 Permanent residential address

Suburb / town	Postcode

Telephone	Fax
Mobile	
Email	

4 Delivery address ☐ Same as residential address

Suburb / town	Postcode

5 Postal address ☐ Same as delivery address (for correspondence)

Suburb / town	Postcode

6 Does the applicant receive Commonwealth Home Support Programme (CHSP) services?

◯ *No, go to **question 7***

◯ *Yes, tick type of CHSP services below:*

☐ Domestic assistance ☐ Centre based respite

☐ In home respite ☐ Personal Care

☐ Nursing care / Continence Nurse Advisor

☐ Other e.g. Allied Health (please list)

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

☐ 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 or Alternative Contact Person

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

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 50

Continence Aids: Initial and Review Application

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Compensation or Insurance Claims

18 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.

Applicant / Carer signature ..... Print name Date

Witness signature ..... Print name Date

Service Improvement Activities

19 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

20 ☐ I agree to accept the conditions stated in the *Applicant Information Sheet*.

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

22 Applicant / Carer signature

..... Print name Date

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

MASS 50

Continence Aids: Initial and Review Application

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

PART B - Continence Aids Application To be completed by the prescriber

Clinical Information Each question must be answered

Refer to the Application Guidelines – Continence Aids

1 **What are the applicant's measurements?** Height ____ cm Weight ____ kg

2 **Has the client had a fall in the last 12 months?** ◯ Yes ◯ No

3 **Was a bone fracture a result of this fall?** ◯ Yes ◯ No

4 **What medical condition(s) and/or other factors contribute to the client's incontinence?**

5 **Attach supporting clinical information for <u>initial</u> application as follows:**

◯ Continence assessment and management/care plan

or

◯ Summary of continence tertiary treatment/intervention

6 **Clinical reason/s for change in type of continence aid:**

7 **Please comment on the review/management of any "transient" causes of incontinence (e.g. urinary tract infection, constipation, psychological issues, mobility/dexterity issues, pharmaceuticals).**

Note: Incomplete application forms will not proceed further, and the prescriber and the applicant will be advised.

Continence Aids Requested

MASS will only supply continence aids on the current MASS Approved Continence Aids list as per website: https://www.health.qld.gov.au/mass/prescribe/continence/products.asp

Name of MASS Approved Aids	Product code	Size required	Quantities of disposable pads used in 24 hours	
			Day time	Overnight

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 50

Continence Aids: Initial and Review Application

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Application Requirements MASS designated prescriber to complete

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 additional supporting documentation if required

Prescriber Details To be completed in full for all applications

8 Family name

9 Given name(s)

10 Profession

11 Registration current?

◯ Yes ◯ No

12 Organisation name

13 Branch

14 Address

Suburb / town | Postcode

15 Contact details

Telephone | Fax

Mobile

Email

16 Postal address ☐ Same as address
(for correspondence)

Suburb / town | Postcode

17 Contact days **Contact hours**

18 Signature

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

Date

Please post or fax completed applications to MASS

Medical Aids Subsidy Scheme
PO Box 281, Cannon Hill Qld 4170
Telephone: 07 3136 3665 or 1300 443 570
Fax: 07 3136 3666 or 1300 446 172
Email: mass184@health.qld.gov.au
Website: www.health.qld.gov.au/mass