



**Medical Aids Subsidy Scheme, Queensland Health**  
**Voice Amplification Device Application Form**  
(This form is an appendix to the MASS 21 Communication Aids Application Form and must accompany all voice amplification device applications)

**MASS**  
**21**  
**App VAD**  
0909

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part E – Clinical Assessment**

Is urgent consideration requested for this application?      No       Yes

If Yes, please provide justification:

**1. Applicant's permanent stabilised disability that necessitates the requested aid:**

**Any other relevant medical history:**

**Comment on the person's abilities in the following areas:**

Physical skills

Sensory skills eg: hearing, vision

Cognitive skills

**2. Does the applicant currently have use of a communication aid?**    Yes     No

If yes, supply brand/model:

Is this a MASS funded aid? Yes  No  If Yes, supply plaque no. (if applicable):

**3. If the applicant already has use of a communication aid, why does this need replacing?**

<input type="checkbox"/> Hired/borrowed	<input type="checkbox"/> Beyond repair (enclose statement from repairer)
<input type="checkbox"/> Functional deterioration	<input type="checkbox"/> Functional improvement
<input type="checkbox"/> Outgrown	<input type="checkbox"/> Other (describe):

Applicant's Full Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Part F – Clinical Justification and Trial of Voice Amplification Device**

Describe the applicant's current communication skills.

How successful is the applicant's communication?

Describe the situations in which the applicant's communication needs are not met.

Describe trial objectives

***Trial of Requested Voice Amplification Device***

Name of voice amplification device trialled:

Comment on: The fit of the equipment (headset/microphone, suitable placement of amplifier, etc.):

Quality of voice amplification:

Applicant's independent use of equipment Eg: physically fit/adjust the headset/microphone and operate the equipment, monitor volume

Applicants /carers reporting of comfort of components, appearance, ease of use.

**Functional use of the device:**

Situations device used in:

Frequency of use:

Speech intelligibility with device:

Were communication needs/objectives met?

Applicant/family satisfaction:

Define outcomes that have determined success:

**MEDICAL AIDS SUBSIDY SCHEME (MASS)**

**Applicant's Full Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Part G – Voice Amplification Device Requested**

Brand	Model	Trial Supplier (if applicable)

**Note:** - Specific brand and model must be specified.

**Part H – Accessories Requested**

List all accessories the applicant requires on the requested aid together with clinical justification to support MASS subsidy funding.

Modification/Accessory	Clinical justification to support MASS subsidy funding

Does the applicant/carer understand the maintenance and use of this device in accordance with MASS and supplier procedures?      Yes  No

Does the applicant/carer understand MASS requirements of private ownership?      Yes  No

**Part I – Prescriber Details – to be completed in full for all applications**

**Prescriber details** (required for return correspondence and queries):

Title:                      Surname:                                      Given Name/s:

Profession:    Registration Current?    Yes  No

Organisation Name:

Organisation Street Address:

Suburb:    Postcode:

Telephone:    Mobile:

Fax:    Contact Hours:

E-mail:

I certify that the information contained in this application is in accordance with the MASS Statewide Prescriber Procedures Manual.

Signature:    Date: