Queensland Government

Medical Aids Subsidy Scheme (MASS)

MASS 60 Orthoses Application

(Affix identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐M ☐F ☐I

APPLICANT INFORMATION

A copy of the applicant eligibility, how to apply, applicant acknowledgements, privacy policy and collection notice is available on the applicant information sheet on the MASS website: health.qld.gov.au/mass/docs

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 Veteran's Affairs (DVA) Pensioner Concession Card (conditions apply)
- Queensland Government Seniors Card

To confirm eligibility: provide a signed consent to access Centrelink information (MASS 84 Proxy Access to Centrelink Information) 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 the information provided by the prescribing therapist as required in the MASS General Guidelines.

Eligible Prescribers

Applicant's wishing to apply to MASS for Orthoses must consult a Private Sector medical specialist as follows:

- Geriatrician
- Neurologist
- Orthopaedic surgeon
- Rehabilitation specialist
- Rheumatologist

MASS SERVICE CENTRE DETAILS

Website: health.qld.gov.au/mass/

Postal Address: PO Box 281, Cannon Hill Qld 4170

Telephone: 07 3136 3696 **Fax:** 07 3220 6398

Email: MASS-SpecialisedServices@health.qld.gov.au

PRIVACY STATEMENT AND COLLECTION NOTICE

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 *Hospital and Health Boards 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. For more information refer to the Queensland Health Privacy Policy.

SW8029
v4.00 - 03/2023

SW8029

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PART A – TO BE COMPLETED BY APPLICANT

APPLICANT DETAILS

Title: **Family name:** **Given name(s):**

Date of Birth: **Gender:** ☐ Male ☐ Female ☐ Intersex or Other ☐ Prefer not to say

Permanent residential address:

Facility/Building Name (if applicable):

Suburb: Postcode:

Delivery address: (for delivery of equipment/aids) ☐ Same as residential address

Suburb: Postcode:

Postal address: (for correspondence) ☐ Same as residential address ☐ Same as delivery address

Suburb: Postcode:

Phone Numbers: Home: Mobile:

Country of Birth: ☐ Australia ☐ Other: ☐ Prefer not to say

Primary language spoken at home: ☐ English ☐ Other: ☐ Prefer not to say

Is the applicant of Aboriginal or Torres Strait Islander Origin?

☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Prefer not to say

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'.

☐ No ☐ Yes - specify level: ☐ Level 1 ☐ Level 2 ☐ Level 3 ☐ Level 4

What is the applicant's current living situation (tick boxes please)?

☐ Hospital, as an inpatient
☐ 24hr supported residential care facility - permanent
☐ 24hr supported residential care facility - respite
☐ Supported community accommodation
☐ Retirement or independent living complex
☐ Private home

Does the applicant receive any other assistance? e.g. NDIS, NIISQ, Palliative care, transitional care.

☐ No ☐ Yes – type of assistance:

Name: Transition care – discharge date:

Concession Eligibility Card Details:

To confirm eligibility, please provide a copy of both sides of your eligibility card OR for Centrelink/ Department of Veterans' Affairs Card Holders: a completed MASS 84 Proxy Access to Centrelink Information form.

☐ Queensland Government Seniors Card
☐ Centrelink Pension Concession Card
☐ Centrelink Health Care Card
☐ Department of Veterans' Affairs Card

Card Number:

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PRIMARY CONTACT, CARER/GUARDIAN, AND ALTERNATIVE CONTACT PERSONS DETAILS

The applicant consents to MASS, Queensland Health approaching their personal contacts should the need arise. The named person below is aware that their name and personal information has been provided to MASS.

Primary Contact Person/Carer/Guardian Details:

Title: Family name: Given name(s):

Relationship to applicant:

Home Phone: Mobile: Work Phone:

COMPENSATION INFORMATION

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?

☐ No ☐ Yes – please complete the details below:

I ☐ have / ☐ have not engaged a legal representative to act on my behalf regarding a claim for damages.

Solicitor's name: Firm's name:

Phone: Fax: Email:

Address: Suburb: Postcode:

Applicant/Guardian or authorised decision-maker on behalf of applicant to complete:

- 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.

Signature: Name: Date:

Witness to complete:

Signature: Name: Date:

MASS EMAIL NOTIFICATIONS

Does the applicant want to join the MASS email notification list to receive material such as newsletters, surveys and information about upcoming educational seminars?

- You may subscribe to receive notifications regarding MASS service improvement activities including receiving newsletters, information about upcoming education workshops and webinars, client surveys and feedback forms. Taking part in these surveys and activities is entirely voluntary, and many surveys can be completed anonymously. Personal information in emails will be handled according to our privacy policy and other legislation that may apply.
- You may choose to stop receiving notifications from MASS by replying "unsubscribe" or "stop" to an email notification; revoking your consent on your next application; or by contacting MASS directly. Choosing to not receive information emails from MASS will not affect services provided.

☐ No ☐ Yes - Email Address:

Queensland Government

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APPLICANT ACKNOWLEDGEMENT

I confirm that:

a. I have actively participated in the assessment and trial of aid/s and associated modifications and accessories.

b. The features and options of the aid/s, and any appropriate alternatives have been fully explained to me by my prescriber.

c. The possible cost implications that I may incur as a result of MASS policy or subsidy funding have been explained to me by my prescriber.

d. The aid/s prescribed are suitable for my needs.

e. The aid/s will only be used by me for the purposes prescribed.

I understand that:

MASS takes no responsibility for any injury sustained by me through the use of the aid subsidy funded by MASS.

I agree to:

a. Use the aid/s within the conditions of MASS

b. Having photographs taken to assist with my application. Refer to MASS 82 MGF/Orthoses Consent to Photograph/Video form.

c. Be willing to participate in a post delivery follow-up with the supplier if it does not meet my functional need within three (3) weeks of receipt of the aid/s.

d. Inform MASS within three (3) weeks of receipt of the aid/s of my satisfaction/dissatisfaction with the aid.

e. Inform MASS within 14 days of any change in my residential address or eligibility for MASS subsidy funding e.g. no longer eligible for a health care card.

Applicant/Guardian or authorised decision maker on behalf of applicant declaration

I agree to accept the conditions stated above: ☐ No ☐ Yes

I acknowledge that my information listed in this application is current and correct: ☐ No ☐ Yes

The applicant consents to MASS using email to contact the prescriber and supplier of the requested aids/equipment and other government departments to confirm eligibility: ☐ No ☐ Yes

Signature: Name: Date:

If authorised decision-maker, specify authority e.g., Power of Attorney, Carer/Guardian/Support Person:

Queensland Government

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Date of Birth: Sex: ☐M ☐F ☐I

PART B – TO BE COMPLETED BY THE PRESCRIBER

CLINICAL ASSESSMENT

1. Primary Diagnosis relevant to this application (please select only one):

☐ Arthritis ☐ Compound fracture ☐ Congenital deformity ☐ CVA/Stroke

☐ Cerebral Palsy – specify: ☐ Diabetes

☐ Degenerative neurological conditions – specify:

☐ Significant Trauma ☐ Other:

2. Is the disability:

a. Permanent: ☐ No ☐ Yes

b. Stable: ☐ No ☐ Yes

3. Is the applicant currently using orthoses? ☐ No ☐ Yes – provide details below:

4. Indicate anatomical site affected: ☐ Left ☐ Right ☐ Bilateral ☐ Spine

5. Type of orthoses:

Foot Orthosis: ☐ UCBL Only

Please note: insoles, inserts, arch supports, heel cushions, heel cups must be applied for with an application for Medical Grade Footwear.

Ankle Foot Orthosis: (AFO)
☐ Fixed ☐ Jointed ☐ Bi-valve
☐ Composite Fixed ☐ Composite Jointed ☐ Additional-sole added
☐ Below Knee Metal Caliper (Single upright) ☐ Below Knee Metal Caliper (double upright)

KAFO: ☐ Custom Made

Knee: ☐ Prefabricated ☐ Fixed Custom ☐ Jointed Custom

Spinal: ☐ Lumbo Sacral ☐ Thoraco Lumbo Sacral ☐ Cervical Thoraco Lumbo Sacral

HKAFO: ☐ Custom

Other:

6. What is the functional outcome expected for use of aid? Please supply details:

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Given Names:

Address:

Date of Birth: Sex: ☐M ☐F ☐I

PRESCRIBER DETAILS

Family name: **Given name(s):**

Profession/Discipline:
☐ Geriatrician
☐ Neurologist
☐ Orthopaedic surgeon
☐ Rehabilitation specialist
☐ Rheumatologist

Current Registration? ☐ No ☐ Yes

Type of Facility: Queensland Health Hospital - ☐ Public ☐ Private OR ☐ Private Consultant

Organisation name:

Branch:

Street address:

Suburb: Postcode:

Contact days: **Contact hours:**

Phone: **Mobile:** **Fax:**

Email:

Signature and date:

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

I accept responsibility for the post delivery follow-up review of the completed Orthoses (or delegate responsibility to the applicant's treating allied health professional in rural and remote areas).

Signature: Date:

PRESCRIBER CHECKLIST

Have you informed the applicant of the following?

☐ 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?

☐ Accurate specification form (where relevant) and full clinical justification for the prescribed equipment?

☐ Provided MASS 82 MGF/Orthoses Consent to Photograph/Video form.

Queensland Government | Medical Aids Subsidy Scheme
Queensland Health

MASS 82
Consent for Photograph / Video
Medical Grade Footwear and Orthoses

(Affix identification label here)

Family name:

Given name(s):

Date of birth: Gender: ☐M ☐F ☐ I

This form is used to give photograph consent to assist with the MASS 60 application process.
As part of the Medical Aids Subsidy Scheme (MASS) application process, clinical eligibility is determined by accessing information from the application form and photographs.
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, except where required by law.

I (1)	(1) Inset full name of applicant/guardian or authorised decision-maker.,
Of (2)	(2) Insert applicant/guardian or authorised decision-makers permanent residential address
On behalf of (3)	(3) Insert full name of applicant
Of (4)	(4) Insert applicant's permanent residential address
Please tick as appropriate ☐ give consent ☐ do not give consent (5)	(5) Applicant is required to provide MASS with consent with reasons, based on privacy, cultural, sex, race or religious concerns for their genuine objection to being photographed or filmed. The prescriber will be required to provide detailed confirmation of the client's eligibility in addition to the application form.
Reason to not give consent (if applicable)	
To (6)	(6) Insert name of prescriber
Of (7)	(7) Insert name of the service provider / agency / organisation and address.

On behalf of MASS to record and submit in photograph of the applicant's (please tick as appropriate):

Medical Grade Footwear
(foot showing the level of deformity present)
☐ Dorsal view, and
☐ Medial or Lateral view

Orthoses
(in situ to demonstrate fit)
☐ Arterior/Posterior, and
☐ Medial or Lateral view

Signature of Applicant/Guardian or authorised decision-maker on behalf of applicant	
Name of Applicant/Guardian or authorised decision-maker on behalf of applicant	Date
If authorised decision-maker, specify authority e.g. Enduring Power of Attorney	

Email, Post OR Fax completed form to a MASS Service Centre

Website: health.qld.gov.au/mass

PO Box 281, Cannon Hill Qld 4170
Email: MASS-SpecialisedServices@health.qld.gov.au
Fax: 07 3220 6398
Telephone: 07 3136 3696

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