Queensland Government

Applicant Information Sheet for MASS 45
Adult Oxygen: Initial Application and 4 Month Review

Applicants 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

Please provide a **copy of both sides of the eligibility card**, OR **signed consent to access Centrelink information** on the *MASS 84 Proxy Access to Centrelink Information Form*.

Clinical eligibility will be determined by the Medical Aids Subsidy Scheme (MASS) Clinical Advisor based on information provided by the MASS designated prescriber as detailed in the MASS General Guidelines.

Domiciliary oxygen is not provided by MASS for hospital inpatients, residents of Commonwealth funded care facilities, Home Care Package Level 1 to 4 recipients and for applicants who are current smokers.

How to Apply

MASS operates through a prescriber model in that MASS designated prescribers, in consultation with the applicant, submit an application (on behalf of the applicant) to MASS for consideration for funding assistance.

The MASS designated prescriber completes the application form in accordance with the General and Oxygen sections of the MASS General Guidelines.

MASS designated oxygen prescribers are:

- Thoracic Physicians
- Specialist General Physicians
- Oncologists
- Cardiologists
- Palliative Care Physicians
- Respiratory Nurse Practitioners
- Neurologists

Refer to Oxygen – Designated Prescriber Chart in the MASS General Guidelines for further details e.g. endorsement requirements for medical practitioners in rural and remote areas.

Applicant Acknowledgement

I confirm that:

1. I have been provided with information by my prescribing medical specialist regarding the safety aspects associated with the use of domiciliary oxygen.
2. I am aware oxygen can be a dangerous fire hazard if used in the vicinity of naked flames.
3. I am a non-smoker and I will not allow others to smoke near my oxygen equipment.
4. I will use the oxygen as explained to me by my prescribing medical specialist.

I acknowledge that

5. the equipment subsidised by MASS always remains the property of the oxygen supplier.
6. repairs must only be carried out by the oxygen supplier.
7. I am responsible for loss of and / or damage of the oxygen equipment.
8. the oxygen and oxygen equipment will only be used for the purpose for which it was prescribed.

Applicant Acknowledgement cont.

9 MASS takes no responsibility for any injuries sustained through the use of the oxygen and oxygen equipment subsidised by MASS.

10 MASS will no longer be financially responsible for the oxygen equipment when any of the following occur:
- I am advised by my prescribing medical practitioner that I am no longer clinically eligible to be provided with oxygen through MASS.
- I am no longer eligible for a Pensioner Concession Card or Health Care Card.
- I no longer reside in the state of Queensland.
- I have moved into a Commonwealth funded aged care facility.
- I do not return the MASS renewal application form by the due date.

I agree to:

11 immediately contact the oxygen supplier if there is any problem with the oxygen equipment.

12 immediately contact MASS or my local Community Health Centre to organise return of the oxygen equipment when it is no longer required. I understand that this must then be followed by confirmation from my doctor in writing.

13 inform MASS within 14 days of any change in my residential address or eligibility for MASS subsidy e.g. if I am no longer eligible for a Health Care Card.

14 keep in good order the oxygen equipment subsidised by MASS.

15 promptly answer any enquiries made by MASS in relation to my need for continued use of oxygen and related oxygen equipment.

16 (concentrator users only) check with my oxygen supplier for instructions and advice if I decide to power my concentrator with a generator. I understand that generators require a minimum set of specifications for powering concentrators and this may vary between machines.

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 *Hospital and Health Boards 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.

Medical Aids Subsidy Scheme
PO Box 281, Cannon Hill Qld 4170
Telephone: 07 3136 3510 or 1300 443 570 | Fax: 07 3136 3500
Email: mass184@health.qld.gov.au
Website: www.health.qld.gov.au/mass

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 45

Adult Oxygen: Initial Application and 4 Month Review

This form is used for all initial domiciliary oxygen applications and the 4 month review application

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: M F I

©The State of Queensland (Queensland Health) 2012 Contact CIM@health.qld.gov.au

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 Intersex or Other

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 Is the applicant receiving a Home Care package? Yes No

NOTE: If the applicant is receiving a Home Care Package, they will not be eligible for oxygen MASS funding.

7 Is the applicant a resident in a Commonwealth funded care facility? Yes No

NOTE: If the applicant is a resident in a Commonwealth funded care facility, they will not be eligible for oxygen MASS funding.

8 Does the applicant receive a Department of Veterans' Affairs benefit? Yes No

9 Does the applicant receive other assistance? (e.g. Dept of Communities / Disabilities, Palliative Care services) Yes No

If *yes*, name

10 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

11 Country of birth

Australia Other

12 Language spoken at home

English Other

Carer or Alternative Contact Person

13 Name

Title	Family name
Given name(s)	

14 Contact information

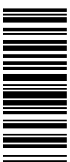
Telephone	Fax
Mobile	
Email	

15 Relationship to applicant

16 Postal address

Suburb / town	Postcode

v2.03-05/2018



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Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 45

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Given name(s):

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Alternate Contact Persons

17 Alternate Contact Persons

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	Personal contact 2
Name in full		
Relationship to applicant		
Residential address		
Telephone		
Mobile		
Email		

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.

	Signature	Print name	Date
Applicant / Carer signature			
Witness signature			

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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 MASS on 07 3136 3510. I understand that there will be no effect to service provision by MASS if I withdraw my consent.

Applicant Acknowledgement

20 **I am a non-smoker and I will not allow others to smoke near my oxygen equipment.**

21 **I agree to accept 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

PART B To be completed by the prescriber

Clinical Assessment

1 **What type of application is this?**

Initial application (measurements required)

4 month review application (repeat measurements required for some categories as per the *MASS Application Guidelines for Oxygen*)

If there are clinical concerns when arranging tests for a particular applicant, the prescriber should contact the MASS Clinical Advisor prior to organising or conducting the tests.

2 **What is the predominant medical condition requiring oxygen therapy?** (tick only one)

Cardiac	Respiratory	Malignancy
Angina, IHD, CAD	COPD	Metastatic Lung (detail below)
CCF	Cor Pulmonale	Primary Lung
Congenital HD	Cystic Fibrosis	
Pulmonary Arterial Hypertension	Interstitial Fibrosis	
	Life Threatening Asthma	
Other cardiac (detail below)	Other respiratory (detail below)	

Other (specify)

3 **Is the applicant a current smoker?** Yes No

4 **Has the applicant been seen by a member of the Palliative Care service?** Yes No

Indication for Oxygen Therapy Categories and measurements required

5 **Select and complete one category only in relation to the predominant medical condition**

Measurements are to be provided by or in consultation with a specialist physician.

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Chronic hypoxaemia category

NB: Applicants should be on room air for a period prior to the test (preferably 20–30 minutes if safe)

i **Arterial blood gas estimations on room air at rest** (required for initial and 4 month review application)

Date	PaO_2 mmHg	$PaCO_2$ mmHg	pH	CO_2 retainer? Yes No	Time off the oxygen prior to test

OR

ii **For applicants in remote areas only when arterial blood gas estimations are unavailable**

Oximetry on room air at rest
(required for initial and 4 month review application)

Date	At rest %	Time off the oxygen prior to test

Hypoxaemia with exercise category

NB: Applicants should be on room air for a period prior to the test (preferably 20–30 minutes if safe)

i **Arterial blood gas estimations on room air at rest** (required for initial application only)

Date	PaO_2 mmHg	$PaCO_2$ mmHg	pH	CO_2 retainer? Yes No	Time off the oxygen prior to test

AND

ii **Exercise oximetry study** (required for initial application) For 4 month review only required on room air.
Oximetry exercise test both on room air and on oxygen to objectively demonstrate desaturation and response to oxygen.

	On room air	**On oxgen**
At rest	%	%
After 6 minute walk test	%	%
Distance walked in 6 minutes	m	m

Demonstrated improvement on oxygen:

Distance:	m
SaO_2	%

For applicants *in remote areas only*, when arterial blood gas estimations are unavailable (i) above does not apply.

Nocturnal hypoxaemia category

NB: Applicants should be on room air for a period prior to the test (preferably 20–30 minutes if safe)

i **Arterial blood gas estimations on room air at rest** (required for initial application only)

Date	PaO_2 mmHg	$PaCO_2$ mmHg	pH	CO_2 retainer? Yes No	Time off the oxygen prior to test

AND

ii **Nocturnal oximetry study** (required for initial application only)

Nocturnal serial oximetry, on room air with readings at regular intervals throughout the sleep period is required to objectively demonstrate oxygen desaturation. Please attach 1) copy of oximetry readings or sleep study report and 2) record the percentage of sleep period with desaturation at 88% or less.

For applicants *in remote areas only*, when arterial blood gas estimations are unavailable (i) above does not apply.

Life threatening asthma category

A thoracic physician must submit applications under this category. **A letter** confirming the life threatening condition requiring oxygen **must be attached** to the application form (required for initial and 4 month review application).

Neurological category

A neurologist or specialist physician must submit applications under this category. **A letter** confirming the neurological condition requiring oxygen **must be attached** to the application form (required for initial and 4 month review application).

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Cardiac category

A cardiologist or specialist physician must submit applications under this category

✓	Specify condition	Requirements
	Pulmonary arterial hypertension	Demonstrated oxygen desaturation on oximetry or arterial blood gases (at rest, on exercise or nocturnal) is required for initial application
	Severe intractable angina when nothing further can be offered in the way of drug therapy or cardiac surgery	No arterial blood gas estimations or oximetry measurements are required
	Recurrent episodic acute pulmonary oedema or severe chronic cardiac failure, when no further drug therapy or surgical intervention is possible or while awaiting heart transplantation	No arterial blood gas estimations or oximetry measurements are required

Other conditions or co-morbidities category

A specialist physician must submit applications under this category following discussion with the MASS Clinical Advisor.

Oxygen Prescription

6 **Flow rates**

Continuous	Exercise	Nocturnal	Asthma	Recommended usage
L/min	L/min	L/min	L/min	hours per 24 hours

Applicant's condition is considered by the treating medical practitioner to be life threatening in the event of power or equipment failure Yes No

Oxygen Equipment

7 **Backup cylinders are only provided to applicants requiring back up oxygen for use in the event of power failure or applicants requiring continuous oxygen for 24 hours per day.**

Emergency Backup Cylinder for Concentrator Users	MASS will subsidise either 3 x "C" or 3 x "CL" or 1 x "E" size emergency backup cylinder(s) per three month period for use in the event of power or equipment failure.

8 **Oxygen equipment requested** (select from either standard or alternative packages)

Standard Packages	**Alternative Packages**	**Accessories**
Concentrator Package **Is backup applicable?** (indicate type) Emergency Backup 'C' Size Cylinder (400 litre), ***OR*** Emergency Backup 'CL' Size Cylinder (690 litre) , ***OR*** Emergency Backup 'E' Size Cylinder (4000 litre)	Maximum 4 cylinders only per month 'C' Size (400 litre) Portable Cylinder Package (Lung Transplantation or Hypoxaemia with Exercise applicants only) ***OR*** 'CL' Size (690 litre) Portable Cylinder Package (Life Threatening Asthma or Hypoxaemia with Exercise applicants only) ***OR*** 'E' Size (4000 litre) Cylinder Package	Cannula and Tubing ***OR*** Mask and Tubing

9 **Does the applicant use a wheelchair or wheeled walking aid?** Yes No

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Continuing Reassessment and Follow-up Prescriber or designated person to complete

Compulsory MASS oxygen review appointment

This section must be completed for the initial application only to ensure ongoing MASS funding

10 Reviewing specialist

Name	Telephone

11 Date of review appointment (must be 3 to 4 months after this initial application)

Hospital Community Liaison Nurse / Discharge Planner / Receptionist

12 Name and contact information

Name	Telephone	Pager
Position	Facility / Department	

13 Has a community health / domiciliary nursing service referral been made?

Yes, please provide name of agency

No, please refer this applicant to the local Community Health Centre for clinical follow-up regarding oxygen therapy.

Prescriber Details To be completed in full for all applications

14 Full Name

15 Medical specialist (state specialty)

OR Other (indicate GP, RMO)

16 Provider number

17 Facility

18 Department

19 Contact Details

Telephone	Fax
Mobile	
Email	

20 Signature

I certify that the information contained in this application is in accordance with the *MASS Application Guidelines for Oxygen*.

Date

Specialist Endorsement

Refer to guidelines for endorsement requirements

21 Full Name

22 Specialty

23 Facility

24 Department

25 Telephone

Post, fax or email completed applications to MASS

Telephone: 07 3136 3510 or 1300 443 570

Post: PO Box 281, Cannon Hill Qld 4170 | **Fax:** 07 3136 3500 | **Email:** mass184@health.qld.gov.au

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