Queensland Government

Applicant Information Sheet for MASS 20 BTA

Static Commode/3-in-1 Commode, Bath Transfer Bench/Swivel Bathseat/Bath lift or similar purpose device, non standard bathboard

For mobile shower commode applications, complete MASS 20 DLA/MOB

The person who will receive the equipment (the 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

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.
5. I have a safety switch/residual current device installed in my home (only applicable for MASS subsidy funded mobility and daily living aids that require charging/ operation through mains power).

I acknowledge that the aid/s provided by MASS are on permanent loan and:

6. remain the property of MASS, unless advised by MASS in writing.
7. will only be used by me for the purposes prescribed.
8. will be maintained by me on a weekly/monthly basis as outlined in the information provided to me with the aid.
9. must be returned to MASS when I no longer require its use or it is replaced, unless advised by MASS in writing.
10. could be allocated from existing MASS stock. MASS may choose to reallocate suitable equipment and not purchase new

11 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.

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

13 unless the equipment is supplied to me with written notification that it has been tested for electrical safety and that the equipment was found to be electrically safe, I should assume that it has not been tested and where the assumption applies, Queensland Health makes no warranty as to the electrical safety of the equipment.

I agree to:

14 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.

15 answer promptly any enquiries made from time to time by MASS service centre as to the condition of the Scheme's aids and my continued need for its safe and effective use.

16 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.

17 use the aid/s within the conditions of MASS.

18 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 an 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:

19 repairs and maintenance become my responsibility.

20 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
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
Website: www.health.qld.gov.au/mass

Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 20 BTA

Static commode/3-in-1 commode, Bath transfer bench/swivel bathseat/bath lift or similar purpose device, non standard bathboard

(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 – 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

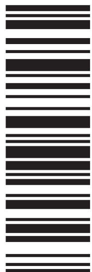
Telephone	Fax
Mobile	
Email	

16 Relationship to applicant

17 Postal address

Suburb / town	Postcode

v3.01 - 06/2016



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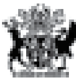

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(Affix identification label here if available)

Family name:

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	✍		

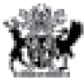
Service Improvements

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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(Affix identification label here if available)

Family name:

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 Bathing and Toileting Aids

Use this form to apply for:

1. Static Commode or 3-in-1 Commode
2. Bath Transfer Bench/Swivel Bathseat/Bath lift/or similar purpose device.
3. Non Standard Bathboard.

NB: If you are applying for any of these items AND other equipment, use the *MASS 20 DLA/Mob Application*

Current versions of all documents can be found on the MASS website: http://www.health.qld.gov.au/mass

Equipment – Request

1 Item/s requested:
- ☐ Static Commode/3-in-1
- ☐ Bath Transfer Bench
- ☐ Bath lift
- ☐ Non standard bathboard
- ☐ Swivel Bathseat
- ☐ Other bathing or toileting device ______________________

2 a) Is this equipment 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 assistive equipment:

5 Provide other relevant information including functional changes and/or comorbidities

6 What are the applicant's measurements?

Height ______ **cm** Weight ______ **kg**

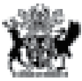
Equipment Request – Static Commode / 3-in-1 Commode

7 Tick boxes that apply:

- ☐ Applicant has a permanent and stabilised condition or disability that prevents effective walking and/or transferring to the toilet in the home
- ☐ Applicant does **not** have a mobile shower chair
- ☐ Commode fits within home environment
- ☐ Clinical justification for additional features or non basic model (e.g. armrests-padded, swing up, modified height)

Please describe:

- ☐ Applicant's weight is within the safe working load of equipment.



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(Affix identification label here if available)

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Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Equipment Request – Bath Transfer Bench/Swivel Bathseat/Bath lift/similar purpose device

8 Tick boxes that apply:

☐ Applicant has a permanent and stabilised condition or disability that prevents effective transfer into a bath or shower

☐ Other options were considered and not suitable (e.g. static shower chair, grab rails etc)

Please list:

☐ Bath Transfer bench or similar purpose device fits within the home environment

☐ Clinical justification for other additional features (suction feet, extended legs)

Please describe:

☐ Applicant's weight is within the safe working load of equipment

Equipment Request – Non Standard Bathboard

9 Tick boxes that apply:

☐ Applicant has a permanent and stabilised condition or disability that prevents effective transfer into a bath or shower

☐ Other options were considered and not suitable (e.g. static shower chair, grab rails etc)

Please list:

☐ Clinical justification for other additional features (raised, extended, padded, backrest):

Please describe:

☐ Applicants weight is within the safe working load of equipment

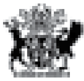
Current Equipment

10 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)



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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Equipment Trial

11 Static Commode/3-in-1 Commode, Bath Transfer Bench/Swivel Bathseat/Bath lift/similar purpose device, non standard bathboard(s) trialled.
Trial is not essential for replacement with same type/size equipment or for Static commodes.

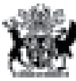
Model / Type / Size	Length and location of trial	Results / comments

Equipment Prescription -SOA Items

Static Commode Prescription

12 Tick one SOA item only. Please obtain quote from supplier if additional options or modifications are required on static or 3-in-1 commode.

Supplier	Model	SWL	Trial supplier
Active Medical Supplies	☐ 1752 Aquacare	125kg	
	☐ 7952PA Aquacare	125kg	
	☐ Trix 61	400kg	
	☐ Trix 71	400kg	
	☐ Trix 91	400kg	
Freedom Healthcare	☐ HBA 370	160kg	
	☐ HBA 409	110kg	
	☐ JBA 500	160kg	
	☐ HBA 400	140kg	
	☐ HBA 406	200kg	
Country Care Group	☐ 12105SJ	110kg	
	☐ 12085	110kg	
	☐ 12247P	110kg	
	12247A ☐ 45P ☐ 52P ☐ 60P	250kg	
	☐ 1222355P	250kg	
	☐ 12224P	250kg	



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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ☐ M ☐ F ☐ I

Equipment Prescription -SOA Items

Static Commode Prescription

Supplier	Model	SWL	Trial supplier
Country Care Group	☐ 12087	150kg	
	☐ 12090	150kg	
	☐ 1208752	250kg	
	☐ 1209052	250kg	
	☐ 1208760	250kg	
	☐ 1209060	250kg	
Elan Medical	☐ Bariatric Commode 70282	295kg	
Medistore	☐ Etac Swift	130kg	
K Care Healthcare	KA500PEHD ☐ 03 ☐ 05	160kg	
	KA500ZD ☐ V03 ☐ V04 ☐ G05	160kg	

Bath Transfer Bench or Swivel Bathseat Prescription

13 Tick one SOA item only. Please obtain quote or complete prescription form from supplier.

Supplier	Model	SWL	Trial supplier
Active Medical Supplies	☐ Aquacare 1018 standard	125kg	
	☐ Aquacare 1018-1 padded	100kg	
	☐ Aquacare 1017 heavy duty	180kg	
	☐ Aquacare 1016-1 sliding	150kg	
	☐ Juvo Bariatric Transfer Bench	200kg	
Freedom Healthcare	☐ HBA 424 heavy duty	200kg	
	☐ HBA 425 rotatable seat	130kg	
	☐ HBA 426 full length seating	160kg	
Country Care Group	☐ 10575SR Bath Transfer Bench	110kg	
	☐ 12183S Swivel Bathseat	110kg	

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(Affix identification label here if available)

Family name:

Given name(s):

Date of birth:

Sex: ☐ M ☐ F ☐ I

Bath Transfer Bench or Swivel Bathseat Prescription

Supplier	Model	SWL	Trial supplier
Medistore	☐ BTSB9016 Swivel Bathseat	110kg	
Surgical Engineering	☐ KIS	150kg	

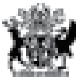
Equipment Prescription - Non-SOA Items

Explain why a non-SOA item has been requested (for Static commode/3-in-1 commode, bath transfer bench or swivel bathseat)

14 Indicate model, supplier and trial supplier.

Model	Supplier	Trial supplier

15 Are accessories required? List and clinically justify.



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MASS 20 BTA

Static commode/3-in-1 commode, Bath transfer bench/swivel bathseat/bath lift or similar purpose device, non standard bathboard

(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

16 Name

Title	Family name
Given name(s)	

17 Profession

18 Current registration? ☐ Yes ☐ No

19 Organisation name

20 Organisation address

Suburb / town	Postcode

21 Contact details

Telephone	Fax
Mobile	
Email	

22 Contact hours

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

Date

Second prescriber (if applicable)

24 Name

Title	Family name
Given name(s)	

25 Profession

26 Current registration? ☐ Yes ☐ No

27 Contact details

Telephone	Fax
Mobile	
Email	

28 Contact hours

29 Please list equipment you have prescribed

30 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
- ☐ included MASS23 Bathboard Specification Form for non standard bathboard requests?
- ☐ (for bath transfer benches or swivel bathseats), provided an accurate quote or supplier prescription form, including accessories.
- ☐ 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):

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: