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Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS CFP10
Cystic Fibrosis Program Application

(Affix identification label here)

Family name:

Given name(s):

Address:

Date of birth: Gender: ☐ M ☐ F ☐ I

DO NOT WRITE IN THIS BINDING MARGIN

Applicant Information Sheet – Applicant / carer to retain copy 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 Veteran's 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) 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. The guidelines are available on the MASS website at health.qld.gov.au/mass

How to Apply

The CFP operates through a prescriber model in that CFP designated prescribers, in consultation with the applicant submit an application (on behalf of the applicant) to the CFP for consideration for aids and equipment assistance. The CFP designated prescriber completes the application form in accordance with the Application Guidelines for Cystic Fibrosis. The guidelines are available on the MASS website at health.qld.gov.au/mass/.

The CFP designated aids and equipment prescribers are:

- Physiotherapists associated with a cystic fibrosis centre or clinic.
- Registered nurses associated with a cystic fibrosis centre or clinic (for nebulisers only).

MASS-eApply is the preferred method for prescribers to submit applications. More information can be found on health.qld.gov.au/mass/mass-online-applications.

Consent to Email Communication

MASS offers applicants the opportunity to communicate by email. This page provides information about the risks of email, conditions for use of email communication and how email communication is used. The form will also be used to document your consent to communicate with you by email.

Risks of communicating via Email

Communication by email has a number of risks which include, but are not limited to, the following:

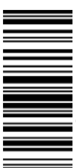
a MASS cannot guarantee that any particular email will be read or responded to.
b An email can be circulated, forwarded and stored in paper and electronic files.
c Backup copies of emails may exist even after the sender or the recipient has deleted their copy.
d Email senders can easily misaddress an email or email can be received by unintended recipients.
e Email communication can be intercepted, altered, forwarded or used without authorisation or detection.

Employers and online services have a right to archive and inspect communication transmitted through their systems.

Conditions for the use of electronic communication

a MASS will use reasonable means to protect the security and confidentiality of information sent and received. However, because of the risks outlined above, MASS cannot guarantee the security and confidentiality of email communication, and MASS will not be liable for the inadvertent disclosure of confidential information.
b Email is not appropriate for urgent or emergency situations, nor is it a substitute for care that may be provided during a face-to-face visit or a telephone/telehealth consultation.
c It is my responsibility to inform MASS of email address changes
d When emailing MASS, I will:
 i Put the applicant name, date of birth and MASS reference number (URN) in the body of the email, not the subject line.
 ii Include the general topic of the email in the subject line. For example, "application status" or "delivery"
 iii Contact MASS via the alternative communication methods (phone, letter etc) if a reply is not received within a reasonable period of time.

V 2.00 10/2021



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e I will not use email for communication regarding sensitive medication information.
f I am responsible for informing MASS of any types of information that I do not want to be sent by email.
g I am responsible for protecting my password or other means of access to email. MASS is not liable for breaches of confidentiality caused by myself or any third party.

Applicant Acknowledgements

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 prescribing health professional.
c The possible cost implications that I may incur as a result of CFP administrative guidelines have been explained to me by my prescribing health professional.
d The aid/s prescribed are suitable for my needs.I have a safety switch (residual current device) installed in my home and am using a surge protection device (only applicable for aids that require charging/operation through mains power).

I acknowledge that:

h The aids provided by the CFP are owned by me and that repairs and maintenance become my responsibility.
i The CFP takes no responsibility for any injury sustained by me when using the aid/s.
j The aid/s will only be used by me and for the purpose prescribed.
k Unless the aid/s is supplied to me with a written notice confirming that it has been tested for electrical safety and that the aid/s 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 (only applicable for aids that require charging/operation through mains power).

I agree to:

l Answer I will not use email for communication regarding sensitive medication information.
m Notify my health professional prescriber should I cease to be able to use the use the aid/s safely and effectively.
n Inform the CFP within 14 days of any change in my residential address or eligibility for assistance e.g. no longer eligible for a Health Care Card.

Privacy Statement

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.

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MASS CFP10

Cystic Fibrosis Program Application

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Given name(s):

Address:

Date of birth: Gender: ☐ M ☐ F ☐ I

Part A – To be completed by the applicant / carer

Applicant's Personal Details

1 Name

Title	Family name	Given name(s)

2 Date of birth

3 Gender

☐ Male ☐ Female ☐ Intersex or Other

4 Address details

Permanent residential address

	Suburb / town	Postcode

Delivery address ☐ Same as residential address

	Suburb / town	Postcode

Postal address ☐ Same as delivery address

	Suburb / town	Postcode

5 Contact Numbers I consent to receive communication regarding this application through SMS ☐ Yes ☐ No

Telephone	Mobile

6 Does the applicant identify with Aboriginal or Torres Strait Islander descent?

☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither

7 Country of Birth

☐ Australia ☐ Other

8 Language spoken at home

☐ English ☐ Other

9 Concession Eligibility Card

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

Card Number

NOTE: 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

Carer Details

Family name	Given name (s)
Relationship to applicant	
Telephone	Mobile

Consent to Email Communication

10 I consent to receiving communication by email regarding this application and the delivery of MASS services ☐ Yes ☐ No

11 I consent to receiving communication by email regarding MASS Service improvement activities. Service improvement activities include surveys, invitations to MASS education sessions workshops and/or webinars, MASS events or newsletters. ☐ Yes ☐ No

12 Email Address

You can withdraw your consent to email communication by contacting MASS.
There will be no impact on service provision should you choose to withdraw consent.

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Applicant Confirmation

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

14 ☐ **I acknowledge that my information listed in this application is current and correct**

15 ☐ **I consent to MASS, Queensland Health approaching my personal contacts should the need arise**

16 ☐ **I have read and fully understand the risks associated with communication of email between MASS and me. I consent to the conditions for the use of email outlined in the *Applicant Information Sheet* as well as any other instructions MASS may communicate to me.**

17 **Signature of Applicant/Guardian or authorised decision-maker on behalf of applicant**

Signature	Name	Date

If the applicant is located in a rural or remote area the designated prescriber/s may sign above as a proxy, with consent, on behalf of the applicant.

Part B – To be completed by the prescriber

Clinical Assessment

1 **Is the applicant a current smoker?** ☐ Yes ☐ No

2 **The aid/s listed below has been trialled by the applicant and is suitable for the applicant.**

Nebulisers ☐ LC Sprint

Nebuliser Masks ☐ Child EFR mask ☐ Baby size 0 ☐ Baby size 1 ☐ Baby size 2 ☐ Baby size 3

Positive Expiratory Pressure (PEP) Systems ☐ S1 ☐ PS ☐ Pressure Manometer ☐ Pressure Indicator

Oscillating PEP ☐ Ball driven ☐ Magnet driven ☐ AB

PEP Masks ☐ Child Silicone Mask Size 2 ☐ Child Silicone Mask Size 3-4 ☐ Adolescent/Adult Silicone Mask Size 4-5

3 **Clinical justification** ☐ Delivery of inhaled medication ☐ Airway clearance

Prescriber Details to be completed in full for all applications

4 **Name**

Family name	Given name(s)

5 **Profession**

☐ Respiratory Physiotherapist ☐ Registered Nurse

6 **Current Registration?**

☐ Yes ☐ No

7 **Organisation Details**

Organisation name	Branch	
Address	Suburb / town	Address

8 **Contact Details**

Telephone	Mobile	Email

9 **Signature and Date**

I certify that the information contained in this application is in accordance with the Application Guidelines for Cystic Fibrosis.

Signature	Date

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Please send completed application to the MASS service centre

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

PO Box 281, Cannon Hill Qld 4170
CFP184@health.qld.gov.au
Telephone: 07 3136 3510