Queensland Government

Medical Aids Subsidy Scheme (MASS) Queensland Health

MASS 21 **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

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth: Sex: ◯ M ◯ F ◯ I

PART B – Clinical Assessment

Is urgent consideration requested for this application? ◯ Yes ◯ No

If yes, please provide justification:

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

Any other relevant medical history:

Comment on the applicant's abilities in the following areas:

Physical skills e.g. manual dexterity

Sensory skills e.g. 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 number (if applicable):

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

☐ Hired/borrowed ☐ Beyond repair (enclose statement from repairer)

☐ Functional deterioration ☐ Functional improvement

☐ Outgrown ☐ Other (describe):

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PART C – Clinical Justification and Trial of Voice Amplification Device

4 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:

5 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 e.g. 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?

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Applicant/family satisfaction:

Define outcomes that have determined success with the device:

PART D – Voice Amplification Device Requested

Brand	Model	**Trial supplier** (if applicable)

Note: • Specific brand and model must be specified.

PART E – 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 F – Prescriber Details To be completed in full for all applications

Prescriber Details (required for return correspondence and queries)

6 Name

Title	Family name
Given name(s)	

7 Profession

8 Eligible for practicing membership of Speech Pathology Australia? ◯ Yes ◯ No

9 Organisation name

10 Organisation address

Suburb / town	Postcode

11 Contact details

Telephone	Fax
Mobile	
Email	
Contact hours	

12 Signature

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

Date