Queensland Government

Medical Aids Subsidy Scheme, Queensland Health

MASS 30 Indigenous Spectacle Supply Scheme

This form is used by prescribing Optometrists/Ophthalmologists

Eligibility

Eligibility is dependent upon the applicant being a permanent Indigenous Queensland Resident.
The applicant must also have a clinical need for spectacles as determined by an Optometrist / Ophthalmologist.

How to Apply

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

The participating Optometrist/Ophthalmologist completes the application form in accordance with the relevant sections in the MASS State-wide Prescriber Procedures Manual.

MASS designated prescribers are any Optometrists/Dispensing Agents/Ophthalmologists participating in the Indigenous Spectacle Supply Scheme (ISSS)

Applicants may also have an eye test with a non-participating Optometrist/Ophthalmologist. The non-participating Optometrist/Ophthalmologist issues a prescription on their business's prescription stationary. The applicant then takes this to a participating Dispensing Agent to complete the application.

Part A – Applicant Acknowledgement

1. I confirm that:
   - I have undergone clinical investigation prior to this application being submitted to MASS.
   - I have actively participated in the selection of the spectacles and they are suitable for my needs.
   - The information provided to the prescriber is accurate and reflects my current health condition.
   - I have been instructed on the use of the prescribed spectacles.
2. I acknowledge that:
   - The features and options of the spectacles have been fully explained as well as possible alternatives that may be available to me through MASS.
   - MASS is unable to exchange requested spectacles once ordered from the supplier.
   - The use of my own frames is at my own risk. MASS will not take responsibility for frames that are lost in the process of being sent from the dispensing agent.
   - MASS requires up to one month to process my application, however if further information is required by MASS regarding the application this processing period may be extended.
   - I have been informed of MASS policy regarding repair of broken/damaged spectacles.
   - I have been advised that my eligibility for ongoing MASS assistance is subject to the outcome of clinical review by an Optometrist/Ophthalmologist.
3. I agree to inform MASS within 14 days of any changes in my residential address or eligibility for MASS funding subsidy.

MASS Privacy Statement

YOUR PRIVACY: The Queensland Health, Medical Aids Subsidy Scheme (MASS) collects administrative, demographic and clinical data as per 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.

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

Medical Aids Subsidy Scheme
PO Box 281, Cannon Hill QLD 4170
Telephone: 07 3136 3696
Fax: 1300 362 276
Email: sss184@health.qld.gov.au
Website: health.qld.gov.au/mass

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Part B – Applicant's Personal Details

Title	**Family Name**	
Given Name(s)	**Preferred name** ☐ First name *or* specify	
Date of Birth	**Gender** ☐ Male ☐ Female ☐ Intersex or Other	
Residential Address		
Suburb/Town		**Post Code**
Postal Address ☐ Same as residential address		
Suburb/Town		**Post Code**
Telephone	**Mobile**	**Email**
Has the application received spectacles previously from MASS? ☐ No ☐ Yes **–** month and year: **/**		
Does the applicant identify with Aboriginal descent? ☐ No ☐ Yes		If answered 'no' to both questions, the applicant is not eligible to receive assistance funding through ISSS.
Does the applicant identify with Torres Strait Islander descent? ☐ No ☐ Yes		

Carer Details

Title	**Given Name**	**Family Name**
Relationship to applicant	**Telephone**	
Postal Address	**Suburb/Town**	**Post Code**
Relationship to applicant		

Applicant Acknowledgement

I agree to accept the conditions stated in Part A of this application. I acknowledge that my information listed in this application is correct.

Applicant/ Carer Signature	**Date**

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Applicant's Full Name: **DOB:** / /

Part C – Clinical Assessment – Spectacle Prescription

Optometrist/Ophthalmologist (Please tick appropriate box)

Complete if spectacles are to be posted to the Applicant:
Applicant's Address:

Street	
Suburb	Post Code

☐ **New application** ☐ **Urgent** ☐ **Resend**

1 Single vision spectacles

Distance	☐
Near/reading	☐

2 Bifocals

Round segment	☐
D segment	☐

3 Trifocals

D segment	☐

4 Special/high powered single vision
(*Issued on clinical need only)*

Distance	☐
Near/reading	☐

5 Lens Material

CR 39	☐

6 Frame

Plastic	☐
Metal	☐
Own: Plastic ☐ Metal	☐

(*Own frames sent to Essilor after approval from ISSS*)

7 Optional Extras To Be Added To Order
(If no clinical need, applicant pays Dispensing Agent Directly)

	Funded (clinical need only)	Unfunded
Tint	☐	☐
Colour		
Percent		
UV Guard	☐	☐
Anti-reflective Coating	☐	☐
Transitions	☐	☐

Other (*Describe in Full)*

Changes to a client's eyesight for spectacles

Adults

Change in hypermetropic or astigmatic refractive error of greater than or equal to 1.0 Dioptre	☐
Change in near prescription greater than or equal to 0.5 Dioptre	☐
Change in myopic refractive error of greater than or equal to 0.5 Dioptre	☐
Change that results in an improvement in overall acuity of two lines or more of Snellen acuity	☐

Children with a presence of

Hypermetropia of +2.00 or more	☐
Astigmatism of -1.0 D or more	☐
Myopia of -0.5 or more	☐
Where there is an improvement in visual acuity of 2 lines or more	☐
Where the child has strabismus requiring refractive correction	☐

Please document all clinical need requests or attach additional information

Script and frame details

R	/	X
L	/	X

PD	ADD	HT	PRISM	
/			R	△B
			L	△B

Distance / Bifocal / Trifocal	Near
Frame code	
Eye size	
Bridge	
Depth/Diagonal	
Colour	

Applicants own frame fitted at own risk

Stamp may be used

Agent Code	
Business Name	
Address	
Phone	Fax
Email	
Signature:	Date / /

MASS

MASS Office Use Only

Dispenser Code	
URN	
Type	
HQ No	
Deliver to	Dispenser ☐ Client ☐