v2.00 - 07/2023

Queensland Government

Medical Aids Subsidy Scheme (MASS)

Client Registration for Queensland Artificial Limb Service (QALS)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Gender: ☐ M ☐ F ☐ I

APPLICANT INFORMATION

A copy of the applicant eligibility, how to apply, privacy policy, guidelines and collection notice is available on the MASS/QALS webpage: https://www.health.qld.gov.au/mass/prescribe/artificial-limbs

Eligibility

The person requiring the funding support for definitive prosthetic services must:

- be aged 65 years or older.
- be an Australian Citizen, Permanent Resident or a holder of a protected special category visa (SCV).
- be listed on a current and open resident (Green) Medicare Card.
- have completed an 'interim rehabilitation program' at a Hospital Amputee or Rehabilitation Clinic, been assessed and deemed competent and suitable to use a prosthetic limb.
- Not be obtaining prosthetic funding support or services through another Government agency or State service.

How to Apply

The person who is applying for registration (the applicant) for QALS must be assessed and deemed competent and suitable to use a prosthetic limb by a Rehabilitation Specialist prior to completing a registration form.

To confirm eligibility, an applicant must provide a copy of their Medicare Card, Citizenship or Visa and proof of residency with their application.

Clinical eligibility (prosthetic clearance and mobility assessment) will need to be provided by an amputee clinic or by a release of information/history of prior use for applicants transferring to QALS.

MASS SERVICE CENTRE DETAILS

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

Postal Address: PO Box 281, Cannon Hill Qld 4170

Telephone: 07 3136 3660

Email: QALS@health.qld.gov.au

PRIVACY CONSENT

This consent is in relation to the collection of information by QH/MSHHS for MASS/QALS funded items

The Queensland Health and Metro South Hospital and Health Service (MSHHS), via the Medical Aids Subsidy Scheme (MASS)/Queensland Artificial Limb Service (QALS) collects and uses your personal information including your administrative, demographic, and health information as part of the MASS application process to assess your eligibility for funding assistance and delivery funded items to your home. All information is collected in accordance with the Information *Privacy Act 2009* (Qld) and *Hospital and Health Boards Act 2011* (Qld). It is important that you have fully read and understood this document before you provide your consent.

MSHHS will collect the following personal information:

- First name, surname, date of birth and demographic information.
- Telephone number/s.
- Residential and delivery addresses.
- Concession card details.
- Details of other support funding received.
- Contact details of nominated contact person/s.
- Information related to your health condition/disability necessitating the supply of aids/equipment.

Not providing requested information may result in your application for aids/equipment being rejected or the approval of the aids/equipment being delayed while the required information is collected. Your personal information will be securely stored and only accessible by authorised employees of Queensland Health/MSHHS.

For information about how Queensland Health protects your personal information, or to learn about your right to access your own personal information, please see our website at http://www.health.qld.gov.au/global/privacy.

CLIENT REGISTRATION FOR QUEENSLAND ARTIFICIAL LIMB SERVICE (QALS)

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PRIVACY CONSENT (CONTINUED)

Your personal information collected may be shared with others directly involved in the provision of MASS services, including:

- Your amputee clinic to confirm clinical eligibility.
- Your selected prosthetic service provider, and other health professionals involved in your prosthetic services, to arrange purchase and delivery of prosthetic services and equipment.
- Other person/s nominated as a contact person on your application if required to act on your behalf.
- Other Hospital and Health Services when your application is related to discharge from a hospital or your rehabilitation after amputation.

Our contracted service providers also observe strict personal information management requirements. To provide services in a timely manner, the most appropriate communication method will be used to share your information including telephone, email, secure data transfer and post. Your information will not be disclosed to other third parties without your consent for any unrelated purpose unless the disclosure is authorised or required by or under law. If you do not wish for us to share your information with a person or organisation, you can ask us not to share it.

At any time during the application process or the use of the funded items, you may withdraw your consent to the sharing of your personal information by informing MASS/QALS by email QALS@health.qld.gov.au or telephone on 07 3136 3660.

To understand our privacy practices more broadly, and your rights in relation to accessing and correcting your personal information, please see https://www.health.qld.gov.au/__data/assets/pdf_file/0027/439164/queensland-health-privacy-policy.pdf.

Substitute decision-maker consent:

If the applicant does not have capacity, you must adhere to the Advance Health Directive (AHD). If there is no AHD, the consent must be obtained from a substitute decision-maker in the following order:

Category - 1. Tribunal appointed guardian; 2. Enduring Power of Attorney; or 3. Statutory Health Attorney.

Name of substitute decision-maker (if applicable):

Category of substitute decision-maker:

Consent:

I consent to QH/MSHHS collecting, storing, using and disclosing my personal information including sensitive information as described in this Consent Form for the purposes of providing me with my health care and the funded items.

Name (Applicant/Substitute Decision-Maker):

Signature: Date:

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PART A – TO BE COMPLETED BY APPLICANT

APPLICANT DETAILS

Title: **Family name:** **Given name(s):**

Date of Birth: **Gender:** ☐ Male ☐ Female ☐ Intersex or Other ☐ Prefer not to say

Permanent residential address:

Suburb: Postcode:

Postal address: (for correspondence) ☐ Same as residential address ☐ Same as delivery address

Suburb: Postcode:

Phone numbers: Home: Mobile:

Does the applicant consent to receiving email communication and notifications regarding this application and QALS/MASS service delivery? ☐ No ☐ Yes

Email address:

Does the applicant require an interpreter? ☐ No ☐ Yes – language spoken:

Country of Birth: ☐ Australia ☐ Other – Specify: ☐ Prefer not to say

Australian Residency/Visa Type:

☐ Australian Citizen ☐ New Zealand Citizen ☐ Protected Special Category Visa
☐ Permanent Residency Visa ☐ Special Category Visa
☐ Other – Specify:

Is the applicant of Aboriginal or Torres Strait Islander Origin? ☐ Prefer not to say
☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander

CARER/GUARDIAN DETAILS

The applicant consents to MASS, Queensland Health approaching their carer/guardian should the need arise. The named person below is aware that their name and personal information has been provided to MASS.

Family name: Given name(s):

Relationship to applicant:

Home phone: Mobile:

ELIGIBILITY DETAILS

Medicare Card Number: ☐ Green ☐ Yellow ☐ Blue

Is the applicant registered with, or receiving funding support through another funding body or service?

☐ Department of Veterans' Affairs (DVA), specify: ☐ Gold Card ☐ White Card ☐ Orange Card
☐ National Disability Insurance Scheme (NDIS)
☐ National Injury Insurance Scheme Qld (NIISQ)
☐ WorkCover
☐ Other – Specify:
☐ No existing funding

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AMPUTATION/LIMB DEFICIENCY AND PROSTHETIC DETAILS

Level and side of amputation/limb deficiency:

Level: ☐ Left ☐ Right **Level:** ☐ Left ☐ Right

Level: ☐ Left ☐ Right **Level:** ☐ Left ☐ Right

Main cause of amputation or limb deficiency:

☐ Circulatory ☐ Diabetes ☐ Medical Negligence ☐ Neurogenic

☐ Congenital (Birth) ☐ Infection ☐ Neoplastic ☐ Traumatic

If cause of amputation was trauma or infection, provide accident/injury details:

Date accident/injury occurred: ☐ Home ☐ Community ☐ Workplace ☐ Motor Vehicle

Chosen prosthetic service provider (PSP) name:
A list of PSPs is available here: https://www.health.qld.gov.au/mass/prescribe/artificial-limbs/qals-groups#PSPs

Have you previously used a prosthetic limb?

☐ No, I am starting the interim rehabilitation program

☐ Yes, Interim limb through hospital

☐ Yes, a Definitive Prosthesis - *complete the below:*

- ☐ Prosthesis was self-funded
- ☐ Prosthesis funded through WorkCover, third party, public risk or other compensation/insurance
- ☐ Transferring from another state or country funding scheme (e.g. Enable NSW, NDIS)

Provide details:

COMPENSATION INFORMATION

Does a WorkCover, third party, public risk or any other form of compensation or insurance claim apply for injuries for which assistance from Queensland Artificial Limb Service is requested?

☐ No, I am not eligible - amputation caused by illness or disease or is congenital

☐ No, I am not eligible - other party was not responsible

☐ No, other reason (specify):

☐ Yes, action has been settled - *provide details and attach a list and/or receipts of prosthetic expenditure*

Date of settlement: Amount of settlement:

☐ Yes, action is being pursued:

I ☐ have / ☐ have not engaged a legal representative to act on my behalf regarding a claim for damages.

Solicitor's name: Firm's name:

Phone: Fax: Email:

Address: Suburb: Postcode:

Provide details of action below:

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MASS MAILING LIST

Does the applicant want to subscribe to receiving notifications regarding MASS service improvement activities such as newsletters, client surveys and upcoming education sessions?

☐ No ☐ Yes – via post ☐ Yes – via email (provide email on page 3).

Taking part in these surveys and activities is entirely voluntary. You may choose to unsubscribe at anytime by replying "unsubscribe" via email; revoking consent on your next application; or by contacting MASS directly. Choosing to not to subscribe to MASS service improvement notifications will not affect services provided.

APPLICANT ACKNOWLEDGEMENTS

1. **I acknowledge that MASS/QALS accepts no liability for any injuries incurred in use of a prosthetic limb, or for loss or damages attributed to the use or misuse of a prosthetic limb:** ☐ Yes ☐ No
2. **I confirm that I am not obtaining prosthetic funding support or services from another Government agency or service (State/National or Overseas); insurance agency; private industry; sponsorship agreements; personal or industry donations; or not-for-profit organisations:** ☐ Yes ☐ No
3. **If I am pursing compensation, I agree to the below conditions:** ☐ Yes ☐ No ☐ Not applicable
   - **a.** I agree any prosthetic services funded by MASS/QALS shall be reimbursed upon reaching a settlement or awarded compensation.
   - **b.** I agree my action will include the pursuit of funds for my future prosthetic needs and these amounts will reflect the standard of service as provided, or recognised by, QALS
   - **c.** I agree to keep MASS/QALS aware of the progress of my action and advise MASS/QALS when a settlement or award is imminent.
   - **d.** I agree to provide MASS/QALS with the appropriate information regarding any award received for any past and/or future prosthetic services
   - **e.** I provide authority for MASS/QALS to contact and provide information to my legal representative named on page 4.
4. **I acknowledge that my information listed in this application is current and correct:** ☐ Yes ☐ No
5. **I authorise the release of my prosthetic service history and information held by any private agency and/or health service to support my application for registration with QALS/MASS.** ☐ No ☐ Yes
6. **I have attached copies of:**
   - ☐ Medicare Card
   - ☐ Proof of Visa OR ☐ Proof of New Zealand Citizenship (e.g. Passport or Birth Certificate)
   - ☐ Proof of residency (e.g. front and back of a driver's license, rental agreement, utility bill)
   - ☐ Settlement compensation claims only: a list and/or receipts of prosthetic expenditure.

Applicant or authorised decision maker declaration, signature and date

Signature: Name: Date:

If authorised decision maker, please specify relationship to applicant (e.g. carer, power of attorney):

Witness to complete:

Signature: Name: Date:

If the applicant is pursing compensation, solicitor to complete:

Signature: Name: Date: