

1 - Client Details

Are you a current client of the Victorian Equipment Program?

Yes No

(If yes, please update Sections 1 and 2 only, if no please complete all sections of this form)

Title Mr Mst Mrs Ms Miss Other

Surname Given Name/s

Male Female Intersex DOB

Accommodation Type

Private Residence Nursing Home (High Care Facility) Hostel (Low Care Facility)
 Supported Residential Service (SRS) Supported Accommodation Services (CRU or group home)

Unit Number Number Street Name

Suburb Postcode

Postal Address (if different from the above)

Contact Home Mobile Email

Preferred method of communication Home Mobile Email Other Please specify

2 – Next of Kin/Contact Person Details

Title Mr Mst Mrs Ms Miss Other

Surname Given Name/s

Relationship to Applicant

Postal Address

Contact Home Mobile Email

Primary contact should be made with Client Next of Kin

3 - Client Demographics

Are you of Aboriginal or Torres Strait Islander origin?

Yes No

Are you in receipt of a pension / allowance / Health Care Card?

Yes No

Type Number

What is your preferred language?

4 –Eligibility Criteria (please note all questions must be answered to determine your eligibility)

Do you have a disability of a permanent nature or are frail aged? Yes No
(If yes, please ask your Doctor to complete Section 8 and submit with this form)

Are you a permanent resident of Victoria? Yes No

Are you on an Australian Government Visa? Yes No Type

Are you an Asylum Seeker? Yes No

Have you been treated as a public hospital in-patient within the past 30 days? Yes No Discharge Date

If yes, what is the name of the Hospital?

Reason for admission

Have you received/are you eligible to receive/are you currently receiving assistance through
(Please Note: The Victorian A&EP is not available to people who have received compensation or damages in respect of their Disability. If the prospective recipient has made, or is intending to make such a claim, the Victorian A&EP shall serve on the recipient notice of liability on the part of the recipient to pay the Victorian A&EP a sum equal to the cost of the equipment, and the Victorian A&EP will seek to arrange for those liabilities to be included in recipient's claim for damages).

Department of Veteran's Affairs Yes No Card Colour

Victorian WorkCover Authority Yes No

Transport Accident Commission Yes No

Legal Claim Yes No

Additional Information
(Please specify date and cover/assistance received if you respond Yes to any of the items above)

Do you have a State or Commonwealth Government Support Package/s Yes No

Please specify name of package received if you respond Yes

Australian Government Home Care Package Yes No

Please specify package level received if you respond Yes Level 1 Level 2 Level 3 Level 4

Name of Case Manager/Coordinator

Organisation

Contact Details

Do you have private health cover with extras?

Yes No

Are you able to claim financial assistance for this equipment through your health fund?

Yes No

5 –Applicant Declaration

I or my authorised delegate confirm that the signature below represents:

- My agreement to enquiries being made by the Department of Human Services or its agent, to other individuals and organisations, for the purpose of obtaining information about eligibility, assessment and supply for the requested aids and equipment and/or modification.
- My understanding that all the information I have supplied on this application is true and correct to the best of my knowledge.
- My understanding that this is not a formal approval or guarantee of Victorian A&EP services.

Name

Signature

Date

6 –Additional Consent

In order to improve the services it delivers, the Department of Human Services may need to use information about you. I consent to information about me possibly being used for service monitoring, evaluation, planning and to improve the quality of services provided to me.

Name

Signature

Date

Your assistance in providing consent for this is appreciated.

7 –Privacy Statement

The Department of Human Services is committed to protecting the confidentiality of your personal information. There are provisions in the Disability legislation that protect the confidentiality of your information. The *Health Records Act 2001* provides additional safeguards and protections for your information. Information that you have provided will only be used to provide services that you request and will not be used for any other purposes without your express consent. You have the right to request access to your information and to have it corrected where it is inaccurate, out of date, incomplete or misleading. For more information about your privacy rights, you can visit the Department of Human Services website at www.dhs.vic.gov.au/privacy or the Office of the Disability Services Commissioner at <http://www.odsc.vic.gov.au/>

8 –Doctors Confirmation

To be completed by doctor providing confirmation of medical diagnosis

I confirm that of
 has a

Diagnosis of

or is

Frail Aged

Doctor Name Doctor Signature

Area of Speciality

Provider Number Date

Contact Details

Please return this completed form to:

State-wide Equipment Program
PO Box 1993
Bakery Hill Vic 3354

Ph: 1300 747 937 (1300 PH SWEP) Fax: 03 5333 8111
Email: swepcentralintake@bhs.org.au

VA&EP Electronic Communication Devices Scheme
P.O. Box 1101
Altona Gate Vic 3025

Ph: 9362 6111 TTY: 9314 9001 Fax: 9314 9759
Email: a&ep@yooralla.com.au