Victorian Aids and Equipment Program (A&EP)

Application for Aids and Equipment

Applicant Details

Title _____ Last Name _____ First Name _____

Male ☐ Female ☐ DISCIS Registration Number (if applicable) _____ Date of Birth _____

Address _____ Suburb _____

Postcode _____ Local Government Area / Council _____ Telephone _____

Next of Kin / Contact Person Details

Last Name _____ First Name _____

Relationship to Applicant _____ Telephone H _____

Address _____ Mobile / Work _____

Please ensure all questions are answered

1. Are you applying for a breast prosthesis? Yes / No
   If yes, go to question 3
2. Do you have a disability of a permanent or indefinite nature? Yes / No
   If yes, please state diagnosis _____
3. Are you a permanent resident of Victoria? Yes / No
4. Are you of Aboriginal or Torres Strait Islander origin? Yes / No
   If yes, please indicate _____
5. Are you in receipt of a pension / allowance / Health Care Card? Yes / No
   Type _____ Number _____
6. Are you in receipt of a Medicare Card? Yes / No Number _____
7. What is your preferred language? _____
8. Are you currently a resident of: *(please provide details)*
   a. Nursing home Yes / No _____
   b. Hostel Yes / No _____
   c. Supported residential accommodation service Yes / No _____
   d. Private / public hospital Yes / No _____
   e. Unit providing subsidised care (eg CRU, group home, training centre) Yes / No _____

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9. Have you received / are you eligible to receive / are you currently receiving assistance through:

(Please specify date and cover / assistance received if you respond Yes to any of these items)

a. Department of Veteran's Affairs *(specify card type)* Yes / No _____

b. Victorian WorkCover Authority Yes / No _____

c. Transport Accident Commission Yes / No _____

d. Legal Claim Yes / No _____

e. HomeFirst Yes / No _____

f. Commonwealth Rehabilitation Service Yes / No _____

g. Community Aged Care Package (CACP) Yes / No _____

h. Extended Aged Care at Home (EACH) package Yes / No _____

i. Program for Students with Disabilities and Impairments / Strategic Assistance for Improving Student Outcomes (SAISO) Yes / No _____

j. Continence Aids Assistance Scheme (CAAS) Yes / No _____

Further comments _____

_____

_____

10. Do you have private health cover with extras? Yes / No Fund _____

Are you able to claim financial assistance with this equipment through your health fund? Yes / No

11. Have you been treated as a public hospital in-patient within the past 30 days? Yes / No If yes, please specify:

Date of discharge	
Name of hospital	
Reason for admission	

12. Have you previously received assistance under the Victorian Aids and Equipment Program (A&EP) or the Program of Aids for Disabled People (PADP)? *(If yes, please provide details)* Yes / No

Type of aid / equipment	Date received	A&EP service provider

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APPLICANT DECLARATION

I confirm that my 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 and assessment for the requested aids and equipment.
- 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 application is not a formal approval or guarantee of A&EP services.
- My understanding that the Victorian A&EP is not available to people who have received compensation or damages in respect of their Disability. But if the prospective recipient has made, or is intending to make such a claim, the Victorian A&EP service provider shall serve on the recipient notice of liability on the part of the recipient to pay the Victorian A&EP service provider a sum equal to the cost of the equipment, and the Victorian A&EP service provider will seek to arrange for those liabilities to be included in recipient's claim for damages.

Authorised Representative or Client **SIGNATURE** _____ **DATE** _____

ADDITIONAL CONSENT

In order to improve the services it delivers, Disability Services may need to use information about you. Your assistance in providing consent for this is appreciated.

I consent to information about me possibly being used for service monitoring, evaluation, planning and to improve the quality of services provided to me.

Authorised Representative or Client **SIGNATURE** _____ **DATE** _____

PRIVACY STATEMENT

Disability 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 DHS website at www.dhs.vic.gov/au/privacy or the Office of the Health Services Commissioner at www.health.vic.gov.au/hsc*

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CONFIRMATION OF DISABILITY

To be completed by person providing confirmation of disability (1, 2 or 3 below)

I _____ confirm that
[print name of signatory]

_____ of
[name of applicant]

_____
[applicant's address]

has a diagnosis of _____
[diagnosis]

which is long term or permanent in nature.

SIGNATURE (Complete ONE only)

1. INITIAL confirmation of disability

Doctor _____ *Date* _____
[signature]

Address _____ *Phone* _____

_____

2. ONGOING confirmation of disability

Assessor _____ *Date* _____
[signature]

Address _____ *Phone* _____

_____

3. Confirmation of disability for people with an intellectual disability, signed by Manager Accommodation Services or Manager Disability Client Services

Disability Services _____ *Date* _____
[signature]

Address _____ *Phone* _____

_____

Please return completed form to the Victorian A&EP service provider at: