

VICTORIAN AIDS AND EQUIPMENT PROGRAM

Application for Aids and Equipment

Applicant Details

Title _____	Last Name _____	First Name _____
Male <input type="checkbox"/>	Female <input type="checkbox"/>	CRIS registration number (if applicable) _____
Date of Birth _____		
Address Residential _____	Suburb _____	
Address _____		
Postal _____		
Post code _____	Shire / Council/ Local Government Area _____	Telephone H _____
		Mobile / Work _____

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. Do you have a disability of a permanent or indefinite nature? Yes / No
If yes, please provide your diagnosis and ensure that relevant details confirming your disability on page 4 are completed. Diagnosis: _____
2. Are you a permanent resident of Victoria? Yes / No
3. Are you on a Permanent Protection Visa – Resolution of Status (RoS) (subclass 851)? Yes / No
4. Are you an Asylum Seeker? Yes / No
5. Are you of Aboriginal or Torres Strait Islander origin? Yes / No
If yes, please indicate _____
6. Are you in receipt of a pension / allowance / Health Care Card? Yes / No
Type: _____ Number: _____
7. What is your preferred language? _____
8. Are you currently a resident of: *(please provide details below)*
 - a. Nursing home (High care facility) Yes / No
 - b. Hostel (Low care facility) Yes / No
 - c. Supported Residential Service (SRS) Yes / No
 - d. Private / public hospital Yes / No
 - e. Supported Accommodation Services - Disability Services (eg CRU or group home) Yes / NoDetails: _____

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 in details below)

- | | | | |
|----|--|----------|------------------|
| a. | Department of Veteran's Affairs (specify card type) | Yes / No | Card type: _____ |
| b. | Victorian WorkCover Authority | Yes / No | |
| c. | Transport Accident Commission | Yes / No | |
| d. | Legal Claim | Yes / No | |
| e. | Independent Support Package Including HomeFirst, | Yes / No | |
| f. | My Future My Choice | Yes / No | |
| g. | Transition Care | Yes / No | |
| h. | Commonwealth Rehabilitation Service | Yes / No | |
| i. | Program for Students with Disabilities and Impairments / Strategic Assistance for Improving Student Outcomes (SAISO) | Yes / No | |
| j. | Contenance Aids Assistance Scheme (CAAS) | Yes / No | |
| k. | Community Aged Care Package (CACP) | Yes / No | |
| l. | Extended Aged Care at Home (EACH) package | Yes / No | |
| m. | Extended Aged Care at Home Dementia (EACH D) package | Yes / No | |

Name of the client's Case Manager/Coordinator/Planner and their phone number if you are for example, receiving a Commonwealth Government CACP, EACH, EACH D, Independent Support Package including HomeFirst, or are on the My Future My Choice or Transition Care Program

Name: _____ Telephone: _____

Details: _____

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) (If yes, please provide details) Yes / No

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

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 issuing centre shall serve on the recipient notice of liability on the part of the recipient to pay the Victorian A&EP issuing centre a sum equal to the cost of the equipment, and the Victorian A&EP issuing centre 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

CONFIRMATION OF DISABILITY

To be completed by DOCTOR providing confirmation of disability

**FOR ECD SCHEME
DOCTOR'S SIGNATURE
MUST FILL IN THIS
FORM AND SIGN TO
CONFIRM DISABILITY**

I (Doctor or
Assessor)

_____ *[print name of signatory]*

_____ of

_____ *[name of applicant]*

_____ *[applicant's address]*

has a
diagnosis of

_____ *[diagnosis]*

which is long term or permanent in nature.

NAME and 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, Manager Disability
Client Services or Plan endorsement signed for My Future My Choice
client by DHS Regional Officer**

*Disability
Services*

_____ *Date* _____
[signature]

Address

_____ *Phone* _____

Email address

**ONCE form is completely filled in
and
signed by the applicant (OR ADVOCATE) and doctor**

**please send back
with
the relevant Speech Pathologist's report
recommending the communication device required to:**

**AEP- ECD Scheme
PO Box 1101
ALTONA GATE, 3025**