

YOORALLA

People Helping People Achieve

Victorian Aids and Equipment Program Electronic Communication Devices Scheme

The Electronic Communication Devices Scheme subsidises the purchase of electronic communication devices and any additional accessories required eg mounts, switches for people with complex communication needs

Eligibility To be eligible the person must:

- Be a resident of Victoria and hold a Medicare Card
- Have a permanent or long term disability and complex communication needs
- Have been assessed by a speech pathologist as requiring a device
- Not be receiving funding through other Government funded schemes such as the Transport Accident Commission or other authorities

Application Process: The application is a four part process:

1. An assessment of the applicant's communication needs must first be undertaken by a Speech Pathologist. This assessment can be provided by a qualified local Speech Pathologist in the community or school or through ComTEC - contact 9362 6111.
2. The Speech Pathologist's report must provide a recommendation for a specific electronic communication device including any necessary accessories such as switches.
3. The attached *Aids and Equipment Application Form (pages 4-8)* must be completed and signed by the doctor to confirm diagnosis
4. The completed *Application Form* and Speech Pathologist's report should be sent to:

**AEP - Yooralla
PO Box 1101
ALTONA GATE, 3025**

Yooralla A.B.N. 14 005 304 432
A.&E.P. - E.C.D. Scheme
705 Geelong Road, Brooklyn 3012
PO Box 1101, Altona Gate, Victoria 3025
Telephone (03) 9362 6111, 1300 885 886 (Victorian Country) Facsimile (03) 9314 9759 Email a&ep@yooralla.com.au
Website www.yooralla.com.auAEP.

DOC.02-R10—01/09

SAMPLE SPEECH PATHOLOGY REPORT FORMAT

for

A &EP Electronic Communication Devices Scheme Application

This is a simple format which may assist you in completing an application for a device from the Scheme. It is not a prescribed format

We do not require a long, extensive report (1-2 pages max) so these guidelines may help in capturing the necessary information.

PART A – Basic Information

- Client's Name
- D.O.B.
- Address
- Contact Person
- Telephone
- Date of Report
- Diagnosis

PART B – Topics to cover

- Background of client
- Current communication
- Communication needs
- Features required in equipment
- Equipment tried/ trialed
- Positioning/ access eg switch and scanning
- **NAME OF SPECIFIC** device recommended including any accessories eg switches, carry bags etc**CHECK WITH SUPPLIER FOR OPTIONS AVAILABLE**

Part C – Signing off report

The report is then completed and signed by the Speech Pathologist and dated and returned with the completed Application Form to the A&EP Office

**AEP -Yooralla
PO Box 1101
ALTONA GATE, 3025**

FOR ANY QUERIES, CONTACT 9362 6154

IMPORTANT NOTE

FOLLOWING IS THE MOST CURRENT

**VAEP
Electronic Communication Device
Scheme**

**APPLICATION FORM
as at January 1, 2009**

**All applications for this AEP funding
must include this new form
before any approval and processing
can be completed**

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 / No
 Details: _____

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 (<i>specify card type</i>) | 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. | Continence 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**