Eligibility and Declaration Form -
Victorian Aids & Equipment Program

1 - Applicant Details

Title ☐ Mr ☐ Mst ☐ Mrs ☐ Ms ☐ Miss ☐ Other (Please Specify) _____

Surname _____

Given Name(s) _____

Gender ☐ Male ☐ Female ☐ Intersex ☐ Transgender

Date of Birth _____

Accommodation Type

☐ Private Residence ☐ Commonwealth Residential Aged Care

☐ Supported Residential Service (SRS) ☐ NDIS Funded Specialist Disability Accomodation

Unit Number _____ Street Number _____

Street Name _____

Suburb _____ Postcode _____

Postal Address *(only complete if different from above)*

Unit Number _____ Street Number _____

Street Name _____

Suburb _____ Postcode _____

Contact Details

Home Number _____ Mobile Number _____

Email _____

Preferred Method of Communication ☐ Home ☐ Mobile ☐ Email ☐ Mail

2 - Next of Kin/Contact Person Details

Title ☐ Mr ☐ Mst ☐ Mrs ☐ Ms ☐ Miss ☐ Other (Please Specify) _____

Surname _____

Given Name(s) _____

Relationship to Applicant _____

Postal Address

Unit Number _____ Street Number _____

Street Name _____

Suburb _____ Postcode _____

Contact Details

Home Number | Mobile Number

Email

Preferred Method of Communication ☐ Home ☐ Mobile ☐ Email ☐ Mail

Primary contact should be made with ☐ Applicant ☐ Next of Kin

3 - Consumer Demographics

Are you of Aboriginal or Torres Strait Islander origin? ☐ Yes ☐ No

Preferred Language:

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

Are you a Participant of the National Disability Insurance Scheme? ☐ Yes ☐ No

Are you in receipt of a Commonwealth Aged Care Home Support Package? ☐ Yes ☐ No

Type: Level:

Are you a Department of Veterans' Affairs Gold Card Holder? ☐ Yes ☐ No

DVA Card Colour

Are you a permanent resident of Victoria? ☐ Yes ☐ No

Are you on an Australian Government Visa? ☐ Yes ☐ No

If yes, what type?

Are you an Asylum Seeker? ☐ Yes ☐ No

Are you on a Temporary Protection Visa? ☐ Yes ☐ No

Are you in receipt of a pension, allowance or Health Care Card? ☐ Yes ☐ No

Type: Number:

Is the client able to claim financial assistance for this item through their private health insurance? ☐ Yes ☐ No

5 - Applicant Declaration

I or my authorised delegate[1] confirm that the signature below represents:

- My agreement to enquiries being made by the Department of Health and Human Services or its agent, to other individuals and organisations, for the purpose of obtaining information about my eligibility, the assessment and supply of the requested Assistive Technology (AT) item and/or modification
- My understanding that:
    - I am not eligible to access support from the VA&EP if I am eligible to become an NDIS participant, unless the need for the AT item is related to a health condition
    - The VA&EP is not available to people who have received compensation or damages that can be used to purchase AT

[1] a legal guardian or power of attorney

- If I make, or intend to make a claim for compensation or damages, my VA&EP service provider will seek reimbursement of the Victorian Government funds that were used to purchase my AT
- The VA&EP will not reimburse or fund any costs associated with the self-purchase of any AT

- I am responsible for notifying SWEP of any changes to my circumstances that may change my eligibility for the VA&EP. This includes:
  - becoming an NDIS participant or recipient of other Government funded schemes
  - becoming a recipient of a Commonwealth Government Home Care Package or entering residential aged care
  - receiving compensation for AT from any other source
  - moving interstate or overseas
- I accept the terms and conditions relating to the supply of the recommended AT item. This includes (where applicable):
  - accepting a re-issue item that meets my assessed needs
  - funding the difference between the cost of the item and the VA&EP maximum subsidy for that item (gap funding)
  - refraining from undertaking modifications or repairs to the SWEP-owned item
  - being responsible for the general upkeep, care of and cleaning of the item, including replacing wheelchair and scooter tyres and tubes as required
  - agreeing, as applicable, to having the item owned by SWEP technically assessed for preventative maintenance checks, including annual electrical safety and weight-bearing capacity checks
  - taking responsibility for organising a mandatory (at minimum 2 year) review of their capacity to safely use any wheelchairs or scooters supplied by SWEP
  - not putting any member of the public at risk through inappropriately or negligently using the SWEP item
  - advising SWEP or my AT practitioner of any change in my physical, cognitive or psychological condition that could affect the safe use of the SWEP item
  - agreeing to a new assessment and any recommendations made by an AT practitioner, including agreeing to collection of the item when it has been determined that this change places me or members of the public at risk through operating the item in a potentially unsafe way
  - considering taking out insurance for the item – for example, insurance for third-party damage, fire and theft for a wheelchair or scooter
- My understanding that to the best of my knowledge, all of the information I have supplied on this application is true and correct
- My understanding that this is not a formal approval or guarantee of support from the VA&EP

Name:

Signature:

Date:

6 - Additional Consent

In order to improve the services we deliver, we 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

We are committed to protecting the confidentiality of your personal information.

Laws protect the privacy of your information. Sometimes your healthcare provider needs to share information with others involved in your care. Everyone involved is legally required to keep your information confidential. You have a right to a say in what happens to your personal health information. You can restrict access to your healthcare record, but it may affect your healthcare provider's ability to give you the best possible care.
You have a right to see your healthcare record. Please tell your healthcare provider if any information is incorrect or incomplete. In some cases, you may be given only part of your record. If so, you have the right to apply under Freedom of Information laws for your complete record.

8 - Practitioner Confirmation

To be completed by a SWEP registered AT Practitioner, providing confirmation of the applicant meeting the VA&EP eligibility requirements

confirm that

Title ☐ Mr ☐ Mst ☐ Mrs ☐ Ms ☐ Miss ☐ Other (Please Specify)

Surname

Given Name(s)

Date of Birth

Unit Number Street Number

Street Name

Suburb Postcode

has a

☐ Diagnosis of

which is long term or permanent in nature, or is

☐ Frail Aged

Practitioner Name:

Signature:

Area of Speciality:

Date:

SWEP Registration Number:

Contact Details:

Please return this completed form to:

Please forward your completed eligibility form to:

State-wide Equipment Program
PO Box 1993
Bakery Hill Vic 3354
Phone: 1300 747 937 (1300 PH SWEP) Fax: 03 5333 8111
Email: swepcustomerserviceteam@bhs.org.au