

# Applicant Information Sheet for MASS60 Medical Grade Footwear Application

The person who will receive the medical grade footwear (applicant) should retain this section for their records.

## Eligibility

Administrative eligibility is dependent upon the applicant being a permanent Queensland resident. The applicant must hold one of the following eligibility cards – in the name of the applicant:

- Centrelink Pensioner Concession Card
- Centrelink Health Care Card
- Centrelink Confirmation of Concession Card Entitlement Form (conditions apply)
- Department of Veterans' Affairs (DVA) Pensioner Concession Card (conditions apply)
- Queensland Government Seniors Card

To confirm eligibility: Please provide a signed consent to access Centrelink information (*MASS 84 Proxy Access to Centrelink Information Form*) **OR** a copy of both sides of the eligibility card.

Clinical eligibility will be determined by the Medical Aids Subsidy Scheme (MASS) Clinical Advisor based on information provided by the prescribing therapist as required in the MASS General Guidelines (<http://www.health.qld.gov.au/mass/>)

## How to Apply

Applicant's wishing to apply to MASS for Medical Grade Footwear must consult a Private Sector medical specialist as follows: • Orthopaedic surgeon • Rehabilitation specialist • Rheumatologist • Geriatrician • Endocrinologist • Vascular surgeon.

**From January to December 2014, public sector podiatrists are also eligible prescribers. Under this trial period for public sector podiatrists, MASS funding will only be eligible for referrals where the client is assessed as high risk or acute.**

## Part A – Applicant Acknowledgement – Retained by the Applicant

### 1. I confirm that:

- I have actively participated in the assessment for the aid/s and associated modifications and/or accessories
- the features and options of the aid/s and any appropriate alternatives have been fully explained to me by my prescriber
- the possible cost implications that I may incur as a result of MASS policy or subsidy funding have been explained to me by my prescriber
- the aid/s prescribed is/are suitable for my needs
- the aid/s will only be used by me for the purposes prescribed.

### 2. I understand that:

- MASS takes no responsibility for any injury sustained by me through use of the aid subsidy funded by MASS.

**Part A – Applicant Acknowledgement – Retained by the Applicant** continued

**3. I agree to:**

- use the aid/s within the conditions of MASS
- have photographs taken to assist with my application. Refer to *MASS 82MGF/ORTHO Consent for Photograph Form*.
- be willing to participate in a post delivery follow-up with the supplier if it does not meet my functional need within 3 weeks of receipt of the aid/s
- inform MASS within 3 weeks of receipt of the aid/s of my satisfaction/dissatisfaction with the aid
- inform MASS within 14 days of any change in my residential address or eligibility for MASS subsidy funding e.g. no longer eligible for a health care card.

**Part A – MASS Privacy Statement**

**YOUR PRIVACY:** The Queensland Health, Medical Aids Subsidy Scheme (MASS) is collecting administrative, demographic and clinical data as part of the MASS application processes, in accordance with the *Information Privacy Act 2009* and *Health Services Act 1991*, in order to assess the applicant's eligibility for funding assistance for the supply of aids and equipment.

The information will only be accessed by Queensland Health officers. Some of this information may be given to the applicant's carer or guardian; other government departments who provide associated services; the prescribing health professional for further clinical management purposes; and to those parties (e.g. community care, commercial suppliers and repairers) requiring the information for the purpose of providing aids, equipment and services.

Your information will not be given to any other person or organisation except where required by law.

**Post OR Fax completed applications to MASS Service Centre**

**Mackay:**

Medical Aids Subsidy Scheme  
PO Box 688, Mackay Qld 4740  
Telephone: 4965 9456 / 1300 738 657 Fax: (07) 3220 6398  
Email: MASS-SpecialisedServices@health.qld.gov.au Website:  
[www.health.qld.gov.au/mass](http://www.health.qld.gov.au/mass)

Queensland  
GovernmentMedical Aids Subsidy Scheme  
(MASS) Queensland Health**MASS 60**  
**Medical Grade Footwear**  
**Application Form**

This form is used for medical grade footwear applications

(Affix identification label here if available)

Family name:

Given name(s):

Date of birth:

Sex: ☐ M ☐ F ☐ I**PART A** To be completed by the applicant / carer**Applicant's Personal Details****1 Name**

Title	Family name
Given name(s)	
Preferred name <input type="checkbox"/> First name or specify	

**2 Date of birth****Sex**☐ Male  
☐ Female**3 Permanent residential address**

Suburb / town	Postcode
Telephone	Fax
Mobile	
Email	

**4 Delivery address** ☐ Same as residential address

Suburb / town	Postcode

**5 Postal address** ☐ Same as delivery address  
(for correspondence)

Suburb / town	Postcode

**6 Does the applicant receive Home and Community Care (HACC) services?** ☐ Yes ☐ No**7 Is the applicant receiving an Extended Aged Care at Home (EACH) package?** ☐ Yes ☐ No**8 Is the applicant a resident in a Commonwealth funded care facility?** ☐ Yes ☐ No

If yes, level <input type="checkbox"/> High <input type="checkbox"/> Low	Facility name
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**9 Does the applicant receive Commonwealth Rehabilitation Scheme assistance?** ☐ Yes ☐ No**10 Does the applicant receive a Department of Veterans' Affairs benefit?** ☐ Yes ☐ No**11 Does the applicant receive other assistance?** (e.g. Dept of Communities / Disabilities, Palliative Care services) ☐ Yes ☐ No

If yes, name

**12 Is the applicant of Aboriginal or Torres Strait Islander origin?** For applicants of both Aboriginal and Torres Strait Islander origin, tick both 'Yes' boxes.Aboriginal ☐ Yes ☐ NoTorres Strait Islander ☐ Yes ☐ No**13 Country of birth**☐ Australia Other **14 Language spoken at home**☐ English Other **Carer or Alternative Contact Person****15 Name**

Title	Family name
Given name(s)	

**16 Contact information**

Telephone	Fax
Mobile	
Email	

**17 Relationship to applicant****18 Postal address**

Suburb / town	Postcode





Queensland  
Government

Medical Aids Subsidy Scheme  
(MASS) Queensland Health

**MASS 60**  
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Sex: ☐ M ☐ F ☐ I

**Compensation or Insurance Claims**

**19 Does a WorkCover, third party, public risk or any other form of compensation or insurance claim apply for injuries for which assistance from MASS, Queensland Health is requested?**

☐ Yes, please complete details below:

☐ No, go to the next section, *Service Improvement Activities*

- I ☐ have / ☐ have not engaged a legal representative to act on my behalf regarding a claim for damages.

Solicitor's name		Firm's name	
Firm's address		Suburb	Postcode
Telephone	Fax	Email	

- I undertake to repay MASS the cost of assistance provided to me by MASS, should I obtain damages for injuries from any past, present or future claim/s.
- I undertake to advise MASS of the progress of my claim for damages. This may be in the form of written communication to MASS from my legal representative.
- I provide authority for MASS to write to and provide information to my legal representative named above.
- This authority remains valid until revoked by me in writing.

**Applicant /  
Carer signature**

Print name

Date

**Witness  
signature**

Print name

Date

**Applicant Acknowledgement**

**20** I agree to the conditions stated in the Applicant Information Sheet.

**21** I acknowledge that my information listed in this application is current and correct.

**22** Applicant/Carer signature

**Signature of Applicant / Carer**

**Name (please print):**

**Date**

**Service Improvement Activities**

Your consent to service improvement activities means that you will be giving MASS your permission to access your health information to improve the care MASS provide to all its clients. These activities will allow MASS to determine if the service is meeting people's needs and the service is complying with standards of practice.

**I agree to participate in MASS service improvement activities (including internal audits and surveys).**

☐ Yes ☐ No

**Signature of Applicant / Carer**

**Name (please print):**

**Date**

At any time I can withdraw my agreement by contacting the MASS Quality Systems Coordinator on 07 3136 3614. I understand that there will be no effect to service provision by MASS if I withdraw my consent.



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(MASS) Queensland Health

(Affix identification label here if available)

MASS 60

## Medical Grade Footwear Application Form

Family name:

Given name(s):

Date of birth:

Sex: ☐ M ☐ F ☐ I

### PART B To be completed by the prescriber

#### Application Current Footwear Status / Profile

Does the applicant **currently** use medical grade footwear? ☐ Yes ☐ No *If yes, please tick below*

☐ Off the shelf (pre-fabricated) **or** ☐ Customised **or** ☐ Custom-made

Is this the same as now being requested? ☐ Yes ☐ No

#### Clinical Assessment

(1) Has the applicant had: ☐ Previous Foot Ulcer/s ☐ Previous Amputation/s ☐ Charcot Neuroarthropathy

(2) Does the applicant have:

☐ Peripheral Arterial Disease (PAD) ☐ Peripheral Neuropathy ☐ Severe Foot Deformity

(2a) As per the NHMRC Foot Deformity Scale, what is the applicant's foot deformity rating (\_\_\_\_/6) for the affected foot? (Please **tick from list below**, where **as each tick = 1 point out of a maximum of 6**. For example, if **bony prominence and hammer toes** are ticked, the score would = 2/6)

☐ Prominent metatarsal heads ☐ Charcot foot deformity ☐ Hammer or claw toes  
☐ Bony prominence ☐ Limited joint mobility ☐ Small muscle wasting

(3) Primary diagnosis relevant to this application (please select only one):

☐ Cancer ☐ Cerebral Palsy .....  
☐ Chronic Kidney Disease ☐ Congenital deformity  
☐ Degenerative neurological conditions .....  
☐ Downs Syndrome ☐ Diabetes ☐ Arthritis  
☐ Significant trauma ☐ CVA / Stroke  
☐ Other .....

(4) Indicate anatomical site affected: ☐ Forefoot ☐ Midfoot ☐ Hindfoot ☐ Other: .....

(5) Functional outcome expected from use of aid:

☐ Hold/maintain position ☐ Enhance transfers ☐ To assist mobility ☐ Pressure offloading  
☐ Other (supply details): .....

#### Photographic Verification

Please attach two photos of the foot showing the level of deformity present (mandatory – to be supplied by prescriber, supplier or client):

☐ Dorsal view, and  
☐ Medial or Lateral view

**Please note:** If images are not clear, further clarification will be sought.



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**Medical Grade Footwear (MGF) Prescription**

(6) Description of footwear required (please tick – refer to the manual for national recommendations):

- ☐ Prefabricated MGF (e.g. extra width/extra depth footwear)  
☐ Customised MGF (i.e. specific individualised alterations/additions to footwear)

**CUSTOMISED MEDICAL GRADE FOOTWEAR**

*Complete Level 1 or Level 2 specification*

**Level 1 Subsidy Amount**

**Description**

- ☐ Heel and sole builds up to 30mm  
☐ Medial / lateral heel and sole postings  
☐ Maximum 1cm forefoot/hind-foot rocker  
☐ Medial / lateral heel or sole floats  
☐ Attachment of hook and loop closures  
☐ Upper stretching/ballooning  
☐ Increase/decrease upper back height  
☐ Split sizes

**Level 2 Subsidy Amount**

**Description**

- ☐ Split sizes with modifications  
☐ Attachment of Caliper Plate/with or without T-strap  
☐ Complex Rocker Action  
(inclusive of other side modification)  
☐ Custom Moulded in-shoe orthosis  
☐ Closure extension of footwear upper  
☐ Sole/Heel build-up over 30mm  
☐ Shoe re-lasting – unilateral/bilateral  
☐ Heel Buttress  
☐ Combination of two or more level 1 modifications

- ☐ Custom made medical grade footwear (requires individual moulds and personalised specifications patterns and lasts for both feet). If selected, please state why 'custom made' footwear is the only prescription *suitable for this applicant*. Please note when applying for custom made footwear, if it is not clear from the clinical information or photos provided, further information may be required to justify why prefabricated MGF is not suitable.

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(7) Modification/components required (including any in-shoe orthotics)

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Given name(s):

Date of birth:

Sex: ☐ M ☐ F ☐ I

### Prescriber Details to be completed in full for all applications

#### 8 Name

Title	Family name
Given name(s)	

#### 9 Profession / Discipline

#### 10 Hospital and Health Service (e.g. Metro South HHS)

#### 11 Facility Name

#### 12 Type of Facility

- ☐ Queensland Health Hospital Podiatrist  
☐ Queensland Health Community Podiatrist  
☐ Private Consultant

13 Current registration? ☐ Yes ☐ No

#### 14 Facility address

<input type="text"/>	
<input type="text"/>	
Suburb / town	Postcode

#### 15 Contact details

Telephone	Fax
Mobile	
Email	

#### 16 Contact hours

#### 17 Signature

I certify that this information is in accordance with the *MASS General Guidelines*. I accept responsibility for the post delivery follow-up review of the completed medical grade footwear (or delegate responsibility to the applicant's treating allied health professional in rural and remote areas)

	Date
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### Prescriber Checklist

Have you informed the applicant of the following:

- ☐ retained a copy of the full application for your reference?  
☐ provided a signed *MASS 84 Proxy Access to Centrelink Information* form or photocopy of both sides of the applicant's concession card?  
☐ provided an accurate quote/s, accurate specification form (where relevant) and full clinical justification for the prescribed equipment?  
☐ have you attached two photos for verification of deformity  
☐ provided *MASS 82MGF/ORTHO Consent for Photograph Form*.

### Office Use Only

☐ Acute Risk ☐ High Risk ☐ At Risk ☐ Low Risk

# MASS 82 MGF/ORTHO - Consent for Photograph Form

**As part of the Medical Aids Subsidy Scheme (MASS) application process, clinical eligibility is determined by assessing information from the application form and photographs. MASS will keep the application and photograph confidential and will only disclose your information with your consent, or if required or authorised by law.**

1 <sup>(1)</sup>	(1) Insert full name of applicant / carer or legal proxy
of <sup>(2)</sup> .....	(2) Insert applicant / carer or legal proxy's permanent residential address
on behalf of <sup>(3)</sup>	(3) Insert full name of applicant
of <sup>(4)</sup> .....	(4) Insert applicant's permanent residential address if different to above
Please tick as appropriate: <input type="checkbox"/> give consent <input type="checkbox"/> do not give consent <sup>(5)</sup>	(5) Applicant is required to provide MASS with reasons, based on privacy, cultural, sex, race or religious concerns for their genuine objection to being filmed. The prescriber will be required to provide detailed confirmation of the client's eligibility in addition to the MASS 60 MGF application form or MASS 60 ORTHO application form.
to <sup>(6)</sup>	(6) Insert name of prescriber/supplier
of <sup>(7)</sup> .....	(7) Insert name of service provider / agency / organisation and address

on behalf of MASS to record and submit in photograph of the applicant's  
(please tick as appropriate):

Medical Grade Footwear  
(foot showing the level of deformity present)

- ☐ Dorsal view, and  
☐ Medial or Lateral view

Orthoses  
(in situ to demonstrate fit)

- ☐ Anterior/Posterior, and  
☐ Medial or Lateral view

<b>Signature of Applicant / Carer / Legal Proxy:</b>	<b>Date:</b>
<b>Full name</b> (please print):	<b>DOB:</b>

**Post OR Fax completed forms to a MASS Service Centre**

**Mackay:**  
 Medical Aids Subsidy Scheme  
 PO Box 688, Mackay Qld 4740  
 Telephone: 4965 9456 / 1300 738 657 Fax: (07) 3220 6398  
 Email: MASS-SpecialisedServices@health.qld.gov.au Website:  
 www.health.qld.gov.au/mass

<b>Applicant's full name:</b>	<b>DOB:</b>
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