Australian Government

Department of Health and Aged Care

Stoma Appliance Scheme Application Form

About this form

Use this form to register your details and eligibility to access products under the Stoma Appliance Scheme (SAS).

Filling in this form

Part 1: to be completed by you – the applicant (or your authorised representative if one has been appointed. See Question 7 for further information regarding authorised representatives).

Part 2: to be completed by a stomal therapy nurse or registered medical practitioner.

Submitting your application

When both parts of the application form are complete, send it to your nominated stoma association for supply of products and services under the SAS. A list of stoma associations and their contact information can be found at: https://australianstoma.com.au/associations/.

For more information

For more information about the SAS and eligibility go to www.health.gov.au/our-work/stoma-appliance-scheme/stoma-appliance-scheme-for-ostomates.

If you need further information or assistance completing this form, call the SAS on 02 6289 2308 Monday to Friday 9am-5pm or email stoma@health.gov.au.

Privacy Notice

Your personal information is protected by law, including the *Privacy Act 1988* and the Australian Privacy Principles. Your personal information is being collected by your stoma association for the primary purpose of assessing your eligibility to access the SAS. This information may be disclosed to the Australian Council of Stoma Associations Inc (ACSA) to support administration of the SAS.

Your personal information will be disclosed to Services Australia to confirm your Medicare eligibility status and may also be used and disclosed for other purposes such as managing payments under the SAS. If you do not provide this information, you will be ineligible for products and services under the SAS.

You can contact your stoma association or ACSA to get more information about the way in which they will manage your personal information.

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PART 1 - Applicant Details

To be completed by the **applicant** or their **authorised representative**, if one has been appointed.

1. Dr ☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Other ☐

Family name

First given name

Second given name (if applicable)

2. Date of birth

/ /

3. Address

State: Postcode:

4. Email or phone number

5. Medicare card number and Reference number

Medicare card expiry date

/

If you do not have a Medicare card, please provide one of the following in the box below:

☐ Department of Veterans' Affairs card number or

☐ Reciprocal Medicare card number or

☐ passport number (if resident of New Zealand or the Republic of Ireland)

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6. Are you completing this form on behalf of the applicant?

☐ No – go to 8 and complete the 'Applicant Consent and Declaration'

☐ Yes – complete 7 and go to 9 and complete the 'Authorised Representative Consent and Declaration'

7. Authorised representative

To complete this form as an applicant's authorised representative, you must:

- hold an enduring power of attorney for the applicant; or
- be an appointed guardian of the applicant; or
- be an Authorised Representative for Medicare purposes – for more information go to: www.servicesaustralia.gov.au/someone-to-deal-with-us-your-behalf

If you have been appointed to act as an authorised representative on the applicant's behalf, please provide your details below:

Name

Email or phone number

Type of representative

☐ Enduring power of attorney

☐ Appointed guardian

☐ Medicare Authorised Representative

Applicant Consent and Declaration

8. Only complete this section if you are the applicant applying for access to the SAS.

- I am the applicant applying for access to the SAS.
- I consent to the collection of my personal information, including sensitive information, by my stoma association for the purposes indicated in this form.
- I understand that giving false or misleading information is a serious offence.
- I agree to adhere to the terms and conditions of the SAS as outlined in the SAS Operational Guidelines available at: www.health.gov.au/resources/publications/stoma-appliance-scheme-operational-guidelines under Section 4 'Requirements of SAS participants'.

Applicant signature

Date

/ /

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Authorised Representative Consent and Declaration

9. Only complete this section if you are completing the form on the applicant's behalf in your capacity as the applicant's authorised representative.

- I am the authorised representative of the applicant applying for access to the SAS.
- I understand that my personal information is being collected by the applicant's stoma association for the purposes indicated in this form.
- I consent to the collection of the applicant's personal information, including sensitive information, by the relevant stoma association for the purposes indicated in this form.
- I understand that giving false or misleading information is a serious offence.
- I agree to adhere to the terms and conditions of the SAS as outlined in the SAS Operational Guidelines available at www.health.gov.au/resources/publications/stoma-appliance-scheme-operational-guidelines under Section 4 'Requirements of SAS participants'.

Authorised representative signature

Date

/ /

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PART 2 – Health Professional Details

To be completed by a stomal therapy nurse or registered medical practitioner.

10. Dr ☐ Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Other ☐

Family name

Given name

11. Professional title

12. Email/phone number

13. Ahpra number

14. Status of stoma:

☐ Permanent

☐ Temporary / reversible

Type of stoma

☐ Colostomy

☐ Ileostomy

☐ Urostomy

☐ Other – provide further information below

Health professional declaration

15. I declare that:

- The applicant is eligible to receive products under the SAS as they do not have normal gastrointestinal tract and/or bladder function and have a temporary or permanent artificial body opening (created surgically or otherwise, including a fistula that originates from the urinary or gastrointestinal tract) which facilitates the removal of urine and/or products of the gastrointestinal tract.
- The information I have provided in this form is complete and correct.

I understand that giving false or misleading information is a serious offence.

Signature

Date

/ /