

APPLICATION FOR MoH COMPLEX EQUIPMENT

PRIORITY	FOR OFFICE USE ONLY
	Application No. _____
	Received <u> </u> / <u> </u> / <u> </u> / <u> </u>

EMS ASSESSOR DETAILS

Name _____ Date of Application / / /

AEA No. _____ Email _____

Telephone _____ Ext No. _____ Fax No. _____

<p>Assessor Declaration</p> <p>By completing and submitting this application I confirm that the assessment and selection of the proposed solution has been personally completed by me and the application is correct and meets the criteria in the current Ministry of Health Equipment and Modification Services Manual (or associated updates).</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Person's Agreement</p> <p>The Person agrees to this application for Equipment being made and that the information given in this application is true and correct. The person has read and signed the Equipment Information form and authorises accessible to use/disclose information as described in the Privacy Act Statement. A signed copy of the Equipment Information form is held on the Assessor's file.</p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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PERSON'S DETAILS

Given Name _____ Title _____

Last Name _____ NHI No. _____

Address Telephone _____

Date of Birth / / /

Gender _____

Ethnicity _____

• Other _____

The Person is: Over 65 Years Under 65 Years Child (Under 16 Years)

The Person Resides: Own Home Residential Care

ELIGIBILITY CRITERIA

Disability Type _____ Primary Diagnosis _____

The Complex Equipment is for:

<input type="checkbox"/> Mobility in the Home	<input type="checkbox"/> Remaining in the Home	<input type="checkbox"/> Full-time Employment	<input type="checkbox"/> Vocational Training
<input type="checkbox"/> Full-time Education	<input type="checkbox"/> Main Carer	<input type="checkbox"/> Communication	<input type="checkbox"/> Voluntary Work

By ticking this box the assessor confirms that rationale has been kept on file for audit purposes which demonstrates how the EMS criteria has been met.

ATTACHMENTS

Please indicate if you have included any of the following attachments by selecting the corresponding check box:

- Complex Wheelchair Specification Sheet** Must be completed and attached if this application includes a request for a wheelchair
- Complex Shower Commode Specification Sheet** Must be completed and attached if this application includes a request for a shower
- Itemised Quote/s from Supplier**
- Evidence of Employment/Education/Vocational Training/Main Carer** Where requested to support Ministry Criteria
- EMS and NASC Joint Report** Where required
- Additional Documentation, Equipment Details or EMS Assessors Report** (Please note these here)

Total Number of pages in this Application _____ Please count all pages including any cover sheets, quotes and equipment specifications and record the number here.

COMPLEX EQUIPMENT EMS ASSESSOR REPORT

Please ensure that this request outlines the essential need for this equipment.

1 Relevant Disability (Include any functional limitations that are relevant to this application)

2 Social Situation and Existing Environment

3 Identified Problems

COMPLEX EQUIPMENT EMS ASSESSOR REPORT

Please ensure that this request outlines the essential need for this equipment.

4 Specific Outcomes To Be Met

5 Identified Alternatives (Provide information on alternative equipment or other options that have been considered; including details as to why these alternatives do not meet the essential needs of the person)

6 Ministry of Health Priority One Indicators If you recommend your application to be considered priority one, please complete the EMS Priority One Form on Page 5

