accessable
ENVIRONMENTAL HEALTH MANAGEMENT SERVICES

APPLICATION FOR MoH EXTRA EQUIPMENT

PRIORITY	FOR OFFICE USE ONLY
	Application No. ____________
	Received dd / mm / yyyy

EMS ASSESSOR DETAILS

Name ______________________ **AEA No.** ____________

Assessor Declaration

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).

☐ Yes ☐ No

Person's Agreement

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 ***accessable*** 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.

☐ Yes ☐ No

PERSON'S DETAILS

Name ______________________ **NHI No** ____________

The Person Lives in a Residential Care Facility: ☐ **Yes** ☐ **No**

Please record the existing Complex Equipment Application Number ____________

Please select one of the following choices:

☐ **Replacement Equipment:** Equipment on the previous application is "worn out" and requires identical replacement.
Complete this page only.

☐ **Additional Equipment Items/Parts or Growth:** Items/parts to be added to the main equipment like pan for commode or mattress for a bed or for changes in size of equipment due to growth.
Complete this page plus Sections 3 and 4 of Page 2 of this form with a brief rationale.

☐ **Additional Equipment:** Extra items to be added within the same accreditation area or equipment type.
Complete this page plus Sections 3, 4 and 5 of Page 2 of this form, plus the EMS Priority One Form on Page 3.

☐ **Trial Continuation:** The equipment items trialled were unsuccessful and further items are requested for trial.
Complete this page plus Sections 3, 4 and 5 of Page 2 of this form providing rationale including why the trial was unsuccessful.

EQUIPMENT DETAILS

	Equipment Description (Include Supplier, Equipment Name and Code)	**Quantity**	**Accreditation**
1	☐ **Purchase** ☐ **Trial** ☐ **Purchase & Trial**		
2	☐ **Purchase** ☐ **Trial** ☐ **Purchase & Trial**		
3	☐ **Purchase** ☐ **Trial** ☐ **Purchase & Trial**		
4	☐ **Purchase** ☐ **Trial** ☐ **Purchase & Trial**		

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☐ **No Equipment Available from Reissue Stock – Please contact supplier for trial.**

☐ **Equipment Available from Reissue Stock – And will be delivered for trial or issued.**

DELIVERY DETAILS

☐ **Person** ☐ **Assessor** ☐ **Other**

Contact Name ______________ **Telephone** ______________ **Ext No.** ________

Delivery Address ______________ **Instructions** ______________

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Person's Name ______________________

Assessor's Name ______________________

Application No. ______________________

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

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 (In order to establish the priority for additional equipment only, please complete the **EMS Priority One Form** on Page 3)

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Equipment and Modification Services (EMS) Priority One Form

This form is to be used for all applications for complex equipment, housing modifications and vehicle purchase and modifications which should be considered as Priority 1.

The person meets one or more of the following indicators for Priority 1

Client Name ____________________

	Yes	No
The person has a documented history of safety issues or has experienced a significant change in their disability status, health or personal circumstances which has affected their (or their family or whanau and other support people) health or safety.	☐	☐
Rationale and Comments:		
The person lives alone, or is alone for the majority of their day and has no other support to assist them with activities of daily living to remain at home or move around their home.	☐	☐
Rationale and Comments :		
The person is unable to, or is at high risk of being unable to, undertake their role as a main carer of a dependent person.	☐	☐
Rationale and Comments :		
The person is unable to express themselves effectively or reliably which impacts on their ability to communicate resulting in imminent risk of harm to themselves, their carers or their dependents.	☐	☐
Rationale and Comments :		
The child or young person is attending compulsory education and is unable to continue with school attendance and their eduactional development.	☐	☐
Rationale and Comments :		

Professional Leader / Clinical Supervisor's confirmation of the application being considered as a Priority 1

Comment :

Date dd / mm / yyyy **Name** ____________________

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