Australian Government
Department of Health

caps | Continence Aids Payment Scheme

Continence Aids Payment Scheme
Application Form

Continence Aids Payment Scheme
Application Form

This application form will allow a person to apply for the Continence Aids Payment Scheme (CAPS).

The CAPS application form has three sections:

Section 1 – Applicant Details – Mandatory

Section 2 – Representative Details – If required

Section 3 – Health Report – Mandatory

Lodgement

Send the completed form to:

Fax: 02 9895 3523

OR

Post: Department of Human Services
Continence Aids Payment Scheme
Medicare Services
GPO Box 9822
Sydney NSW 2001

Applications are no longer accepted by email

Print in **BLOCK LETTERS**

Tick where applicable ☑

Important information

CAPS application forms must be sent to Medicare as per the above lodgement details.

You must read the information below and the CAPS application guidelines before completing this form in black or blue pen only.

Who can complete this form?

- the applicant

The following people can complete and sign this form on behalf of the applicant:

- a parent, if the applicant is under 14 years of age, or the applicant is at least 14 years but has not turned 18 years of age and does not have the capacity to act on their own behalf. Note: Unless contrary information is provided, the custodial parent of an applicant under 14 is to complete this form and receive correspondence and the payment on the applicant's behalf; or
- a legal representative, including a person nominated under a Power of Attorney, an appointed legal Guardian or a Public Trustee, with authority to act on the applicant's behalf.

If the applicant is unable to act on their own behalf because of a physical or mental impairment and has no legal representative authorised to act on their behalf, then the following persons can act on behalf of the applicant:

- an applicant's Centrelink Correspondence Nominee, as recognised by Centrelink for the purposes of the Social Security Law; or
- a Department of Veterans' Affairs (DVA) Trustee, as recognised by DVA for the purposes of veterans' entitlements law.

If no other representative exists, then a responsible person, who has been approved by the Secretary of the Department of Health (Department), in writing, may act on the applicant's behalf.

For further information on how to apply for responsible person status, call the National Continence Helpline on 1800 330 066 or visit www.bladderbowel.gov.au

Who can receive payments?

CAPS payments can be made to one of the following:

- the applicant;
- a parent, if the applicant is under 14 years of age, or the applicant is at least 14 years but has not turned 18 years of age and does not have the capacity to act on their own behalf. Note: Unless contrary information is provided, the custodial parent of an applicant under 14 is to receive the payment on the applicant's behalf;
- a legal representative, including a person nominated under a Power of Attorney, an appointed legal guardian or a Public Trustee, with authority to receive payments on the applicant's behalf;
- an applicant's Centrelink Payment Nominee, as recognised by Centrelink for the purposes of the Social Security Law;
- a DVA Trustee, as recognised by DVA for the purposes of veterans' entitlements law;
- a DVA Agent, as recognised by DVA for the purposes of veterans' entitlements law;
- a responsible person who has been approved by the Secretary of the Department, in writing, to receive a CAPS payment on an applicant's behalf; or
- an organisation (other than a legal representative) that agrees to assist with the purchase of continence or continence related products for an applicant.

Payments to organisations

If an organisation agrees to receive CAPS payments as an agent of an applicant, then the organisation must complete the *Organisation authorised as payment recipient* section of this form. Any person authorised to complete this form may authorise the payment be directed to an organisation.

Obligations of payment recipients

A person or an organisation that receives a payment as an agent of an applicant must:

- ensure the CAPS payment is used exclusively for the benefit of the applicant; and
- ensure the CAPS payment is used solely for the purpose of purchasing continence and continence related products.

Medicare records

A Centrelink Correspondence Nominee, a DVA Trustee or a responsible person authorised by the Secretary of the Department is able to update information about the applicant for the purposes of CAPS and provide bank details for CAPS payments. However, they are not able to update the applicant's Medicare record, including bank account details used by Medicare to make Medicare payments, or update the address details used by Medicare for Medicare-related purposes.

Privacy and your personal information

Personal information is protected by law, including by the *Privacy Act 1988*.

The information provided on this application will be stored and used by Medicare for the purposes of making payments and issuing correspondence for the CAPS program.

This information may also be used to update the applicant's existing personal information held by Medicare.

The collection of this information is authorised by the Human Services (*Medicare) Act 1973*.

The information may be disclosed to person/s or organisations authorised to receive payments and/or correspondence on behalf of the applicant, relevant financial institutions to facilitate payment, the Department of Health, other relevant government agencies or as authorised or required by law.

Change of circumstances

Medicare must be notified if a CAPS participant ceases to be eligible for the CAPS payments. Medicare must also be notified if a CAPS participant's, or their representative's, circumstances change. You can do this by calling Medicare on **132 011** select general enquiries (call charges may apply) between 9:00am and 5:00pm AEST.

Assistance

If you need assistance completing this form call Medicare on **1800 239 309**. For more information about the CAPS call the National Continence Helpline on **1800 330 066** or go to **www.bladderbowel.gov.au**

ELIGIBILITY GUIDE

To be eligible for the CAPS an applicant must be five years of age or older and meet one of the following requirements:

A have permanent and severe loss of bladder and/or bowel function (incontinence) due directly to **an eligible neurological condition**; or

B have permanent and severe loss of bladder and/or bowel function (incontinence) caused by **an eligible other condition**, provided the applicant has a Centrelink or DVA Pensioner Concession Card or entitlement, whether as primary cardholder or a dependant of a cardholder.

Responses to the six questions below will further indicate whether the applicant is eligible for the CAPS. Please refer to CAPS application guidelines. **The following questions must be answered**.

E1 Is the applicant an Australian Citizen?

Yes ☐ No ☐

E2 Is the applicant a permanent Australian resident?

Yes ☐ No ☐

E3 Is the applicant a permanent high care resident in an Australian Government funded aged care home?

Yes ☐ No ☐

If the answer is **Yes**, then the applicant is not eligible for assistance from CAPS. Refer to CAPS application guidelines.

E4 Does the applicant receive an Australian Government funded Home Care Package and continence products are negotiated as part of the applicant's care plan?

Yes ☐ No ☐

If the answer is **Yes**, then the applicant is not eligible for assistance from CAPS. Refer to CAPS application guidelines.

E5 Is the applicant eligible to receive assistance with continence products from the Department of Veterans' Affairs Rehabilitation Appliance Program (RAP)?

Yes ☐ No ☐

If the answer is **Yes**, then the applicant is not eligible for assistance from CAPS. Refer to CAPS application guidelines.

E6 Does the applicant receive funding from the Australian Government National Disability Insurance Scheme and continence products are negotiated as part of the applicant's plan?

Yes ☐ No ☐

If the answer is **Yes**, then the applicant is not eligible for assistance from CAPS. Refer to CAPS application guidelines.

SECTION 1 – APPLICANT DETAILS

Applicant Details

A1 Medicare card number

☐☐☐☐ – ☐☐☐☐☐ – ☐

Ref No. ☐

A2 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Family name (as recorded on the Medicare card)

First given name

A3 Date of birth

/ /

dd mm yyyy

A4 Sex: Male ☐ Female ☐

A5 Home phone number

( )

Work phone number (optional)

( )

Mobile phone number (optional)

Email address (optional)

@

A6 Applicant's residential address

State Postcode

Applicant's postal address

State Postcode

A7 Who will be signing the applicant declaration or representative declaration section of this form?
(see Who can complete this form? on page 1)

☐ Applicant Go to A8

☐ Applicant's parent Go to A8

☐ Applicant's legal representative Go to A8

☐ Other Go to A9

A8 Do you want the applicant's Medicare card address to be updated with the address provided at question A6?

Yes ☐ No ☐

A9 Is the applicant of Aboriginal, Torres Strait Islander or South Sea Islander origin?

☐ No

☐ Yes – Aboriginal

☐ Yes – Torres Strait Islander

☐ Yes – Australian South Sea Islander

A10 Where was the applicant born?

☐ Australia

☐ Other – Specify country:

A11 Does the applicant have a Centrelink or DVA Pensioner Concession Card (PCC), or is the applicant listed as a dependant on their parent or guardian's PCC?

Yes ☐ Go to A12

No ☐ Go to A13

A12 Applicant's Centrelink or DVA Number as recorded on the PCC.

PCC: ☐☐☐ – ☐☐☐ – ☐☐☐ – ☐

DVA:

Correspondence recipient

question continues next page…

A13 Is a person other than the applicant to receive the correspondence?

Yes ☐ Go to A14

No ☐ Go to A18

A14 Who is to receive the CAPS correspondence on behalf of the applicant?

☐ Applicant's parent (applicant under 14 years of age)

☐ Applicant's parent (applicant 14 to 17 years of age)

☐ Person appointed under a Power of Attorney

☐ Person appointed under an Enduring Power of Attorney

☐ Appointed legal guardian

☐ Centrelink Correspondence or Payment Nominee

☐ DVA Trustee or Agent

☐ Responsible person approved by the Secretary of the Department to act on the applicant's behalf

☐ Other – If other, specify:

A15 Family name of correspondence recipient

First given name of correspondence recipient

A16 Correspondence recipient's address

A17 Correspondence recipient's daytime contact number

Payment Details

A18 CAPS payments can be received annually in July or half yearly in July and January. Tick one of the payment options below:

☐ Full payment in July

☐ Half payments in July and January

A19 Is a representative or an organisation that is able to assist with the purchase of continence products to receive the CAPS payment on behalf of the applicant?

Yes ☐ Go to A23

No ☐ Go to A20

A20 Applicant's nominated bank account details

Name of applicant's nominated bank, building society or credit union

Branch where the account is held

Branch number (BSB)

☐☐☐ – ☐☐☐

Account number

Account held in the name(s) of

A21 Is a person other than the applicant signing the declaration on this form?

Yes ☐ Go to Section 2 – Representative details.

No ☐ Go to A22

A22 Applicant's declaration

I am the Applicant and I declare that:

- I have read the CAPS application guidelines;
- the information on this form is true and correct; and
- I will inform Medicare without delay of any changes to the information provided in this form.

I acknowledge:

- giving false or misleading information is a serious offence and may lead to prosecution under the *Criminal Code Act 1995*;
- I may be asked to confirm my eligibility for CAPS payments; and
- the CAPS payment provided is for the purchase of continence products.

Signature

Date

dd mm yyyy

question continues next page…

Privacy Note
Personal information is protected by law, including by the *Privacy Act 1988*. Refer to page 2.

A23 Is the CAPS payment to be made directly to an organisation or a representative?

No ☐ The applicant does not need to complete any further questions – the Health Report – Section 3 is to be completed by a Health Professional.

Yes ☐ Go to Section 2 – Representative details for a representative or R15 to direct payment to an organisation.

NOTE: In all circumstances, for an applicant to be assessed as eligible, a Health Professional is required to complete Section 3 – the Health Report of this form. Please ensure the Health Professional has completed and signed Section 3 before returning this application to Medicare.

SECTION 2 – REPRESENTATIVE

(see

Certified copies of legal documents are to be provided
send original documents. A certified copy is a copy of an original document that has been certified as a true and correct copy

For a DVA Trustee or Agent:

- a DVA appointment of Trustee or Agent document.

Copies of original documents from Centrelink and DVA can be provided however, if they are copies, they need to be certified.

For a responsible person approved by the Secretary of the Department:

- evidence of the Secretary of the Department's written approval of the person as a responsible person for the applicant.

The representative should advise Medicare if they no longer have authority to act on behalf of the applicant. An applicant can advise Medicare at any time if they wish to terminate their representative's authority to act on their behalf (other than a legal representative).

R1 What authorised actions will the representative be undertaking on behalf of the applicant?

☐ Signing the form only Go to R8

☐ Receiving the CAPS payment only Go to R2

☐ Signing & directing the CAPS payment to an organisation Go to R8

☐ Signing & receiving the CAPS payment Go to R2

NOTE: If the payment representative and the signing form representative are different people, the payment representative is to complete the details in R2 to R7 and the signing form representative is to complete R8 to R12.

Representative receiving payment *or* receiving payment and signing form on behalf of the applicant

R2 What is the relationship of the representative receiving the payment or receiving payment and signing form, to the applicant?

☐ Applicant's parent (applicant under 14 years of age)

☐ Applicant's parent (applicant 14 to 17 years of age)

☐ Person appointed under a Power of Attorney

☐ Person appointed under an Enduring Power of Attorney

☐ Appointed legal guardian

☐ Other legal representative, specify

☐ Centrelink Correspondence Nominee (may sign form)

☐ Centrelink Payment Nominee (may receive payments only)

☐ DVA Trustee (may sign form and receive payments)

☐ DVA Agent (may receive payments only)

☐ Responsible person approved by the Secretary of the Department to act on the applicant's behalf (may sign form and/or receive payments)

☐ Responsible person approved by the Secretary of the Department to receive payments on applicant's behalf (may receive payments only)

R3 Organisation name (only if required), for example if representative is a Public Trustee or a disability facility.

Name of contact person in organisation

Contact person's position

R4 Family name of representative

First given name of representative

R5 Address

R6 Daytime phone number

Representative's bank account details

R7 Name of bank, building society or credit union

Branch where the account is held

Branch number (BSB)

☐☐☐ – ☐☐☐

Account number

Account held in the name(s) of

NOTE: If a representative is not signing the declaration on behalf of the applicant there are no further questions. Section 3 – the Health Report needs to be completed by a Health Professional.

Representative signing form ONLY

R8 What is the relationship of the representative signing the form to the applicant?

☐ Applicant's parent (applicant under 14 years of age)

☐ Applicant's parent (applicant 14 to 17 years of age)

☐ Person appointed under a Power of Attorney

☐ Person appointed under an Enduring Power of Attorney

☐ Appointed legal guardian

☐ Other legal representative, specify

☐ Centrelink Correspondence Nominee

☐ DVA Trustee

☐ Responsible person approved by the Secretary of the Department to act on the applicant's behalf

R9 Organisation name (if required), for example if representative is a Public Trustee or a disability facility.

Name of contact person in organisation

Contact person's position

R10 Family name of representative

First given name of representative

R11 Address

R12 Daytime phone number

Representative's declaration

R13 I am the:

- ☐ Applicant's parent (applicant under 14 years of age)
- ☐ Applicant's parent (applicant 14 to 17 years of age and does not have the capacity to act on their own behalf)
- ☐ Person appointed under a Power of Attorney
- ☐ Person appointed under an Enduring Power of Attorney
- ☐ Applicant's appointed legal guardian
- ☐ Applicant's other legal representative, specify

  ☐
- ☐ Applicant's Centrelink Correspondence Nominee (applicant unable to act on own behalf due to a physical or mental impairment)
- ☐ Applicant's DVA Trustee (applicant unable to act on own behalf due to a physical or mental impairment)
- ☐ Responsible person approved by the Secretary of the Department to act on the applicant's behalf

I declare that:

- I have read the CAPS application guidelines;
- the information on this form is true and correct; and
- I will inform Medicare without delay of any changes to the information provided in this form; and

I acknowledge:

- giving false or misleading information is a serious offence and may lead to prosecution under the *Criminal Code Act 1995*;
- I may be asked to confirm the applicant's eligibility for CAPS payments; and
- the CAPS payment provided is for the purchase of continence products for the applicant.

Signature

☐

Date

☐

dd mm yyyy

Privacy Note
Personal information is protected by law, including by the *Privacy Act 1988*.

R14 Do you wish the CAPS payment to be made directly to an organisation?

Yes ☐ Go to R15

No ☐ You do not need to complete any further questions – the Health Report – **Section 3** is to be completed by a Health Professional.

R15 Authorising payment to an organisation

If an organisation agrees to receive the CAPS payments on behalf of an applicant, the organisation must complete the *Organisation authorised as payment recipient* section (see page 8) of this form.

I am the:

- ☐ Applicant
- ☐ Applicant's parent (applicant under 14 years of age)
- ☐ Applicant's parent (applicant 14 to 17 years of age)
- ☐ Person appointed under a Power of Attorney
- ☐ Person appointed under an Enduring Power of Attorney
- ☐ Applicant's appointed legal guardian
- ☐ Applicant's other legal representative, specify

  ☐
- ☐ Applicant's Centrelink Correspondence Nominee
- ☐ Applicant's DVA Trustee
- ☐ Responsible person approved by the Secretary of the Department to act on the applicant's behalf

I authorise the CAPS payment to be paid to the following organisation:

Organisation name

☐

Organisation's Australian Business Number (ABN)

☐

Signature

☐

Date

☐ / ☐ / ☐

dd mm yyyy

Privacy Note
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NOTE: In all circumstances, for an applicant to be assessed as eligible a Health Professional is required to complete **Section 3** – the Health Report of this form. Please ensure the Health Professional has completed and signed **Section 3** before returning this application to Medicare.

Organisation authorised as payment recipient

If an organisation agrees to receive CAPS payments on behalf of an applicant, the organisation must complete this section of the form.

Organisation details

R16 Organisation name

R17 Organisation's Australian Business Number (ABN)

R18 Name of organisation's authorised representative

R19 Position of organisation's authorised representative

R20 Contact number

R21 Organisation's business address

R22 Organisation's postal address

Organisation's bank account

CAPS payments will be made to this bank account. The account recorded must be an Australian bank account. Payments cannot be made into credit cards, loan or mortgage accounts.

R23 Name of bank, building society or credit union

Branch where account is held

Branch number (BSB)

Account number

Account name

Organisation's declaration

R24 I declare that:

- I am an authorised representative of the organisation identified at Question R18;
- as the representative of the organisation, I am authorised to bind the organisation;
- the information on this form is true and correct; and
- the organisation will inform Medicare without delay of any changes to the information provided in this form.

The organisation will:

- ensure the CAPS payment is used exclusively for the benefit of:

Applicant's name

Applicant's date of birth

- ensure the CAPS payment is used for the purchase of appropriate continence products or continence related products for the applicant;
- keep a record of all CAPS payments received;
- keep records of continence and continence related aids purchased using a CAPS payment (or a portion of a CAPS payment); and
- return any unused CAPS payments to the applicant, or the applicant's estate, if advised that the applicant has died, is not eligible or is no longer eligible, or the applicant or their representative terminates the payment arrangement with the organisation.

I acknowledge:

- giving false or misleading information is a serious offence and may lead to prosecution under the *Criminal Code Act 1995*.

Signature

Date

dd mm yyyy

Privacy Note
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NOTE: The organisation should check that the Health Report – Section 3 has been completed before forwarding the application to Medicare.

Instructions for Health Professional

Please ensure you have read the CAPS application guidelines.

You should only complete this Health Report if you are in a position to make an accurate assessment of the applicant in relation to their incontinence and its cause.

If in doubt, check the website www.bladderbowel.gov.au

H1 Name of the applicant

Applicant's Date of Birth

dd mm yyyy

H2 Do you have a Medicare Approved Provider Number?

No ☐

Yes ☐ What is your Approved Provider Number?

H3 Health Professional's Family Name

Given Names

H4 Health Professional's contact details

Phone Number

Mobile Phone Number

Fax Number

Email address

Business or Employer's Business Name

Work Address

H5 To which health profession do you belong?

- ☐ Continence Nurse
- ☐ General Practitioner
- ☐ Medical Specialist
- ☐ Community Nurse
- ☐ Physiotherapist
- ☐ Occupational Therapist
- ☐ Registered Nurse
- ☐ Aboriginal Health Worker
- ☐ Other (specify)

H6 Are you in a position to make an accurate continence assessment of the applicant?

Yes ☐ No ☐

H7 Are you aware of a continence management plan for the applicant or can you refer the applicant for a continence management plan?

Yes ☐ No ☐

H8 Is the incontinence caused by an eligible *Neurological* condition?

No ☐

Yes ☐ Specify Neurological condition

H9 Is the incontinence caused by an eligible *other condition* and the applicant has a valid Centrelink or DVA Pensioner Concession Card (PCC) entitlement or is listed as a dependant?

No ☐

Yes ☐ Specify other condition

H10 Does the applicant have permanent and severe loss of bladder function?

Yes ☐ No ☐

H11 Does the applicant have permanent and severe loss of bowel function?

Yes ☐ No ☐

H12 Health Professional Declaration

I declare:

- I have assessed the applicant identified at H1 and A2; and
- to the best of my knowledge the information provided in this Health Report is true and correct.

Signature

Date

dd mm yyyy

Privacy Note

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12290 October 2018

www.health.gov.au

All information in this publication is correct as at October 2018.