# Request Form GEAT Generic

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| **Important**   * Please complete ALL sections * Before your client can access any government-funded aged care services, they must first be registered with My Aged Care. * This form is for use by health professionals when assessing if goods, equipment and assistive technology items are required to maximise a person’s safety and/or independence in their own home. * Where this request is being provided as part of a CHSP Allied Health service please upload this form under other attachments in the My Aged Care Provider Portal to facilitate the provision of service. |

**Customer Details**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: | Name | Phone Number: | Phone | | DOB: | DOB |
|  | | | | | | |
| Email for correspondence: | Email. | Email to the ATTN of: (if not Customer) | | Attention to. | | |

**Customer My Aged Care Registration**

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| *Indigo cannot progress this request until a referral from My Aged Care for GEAT services has been received.* | | | |
| My Aged Care ID: | Age Care ID. | GEAT referral retrieval code: | GEAT code |

**Health Professional Details**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name: | HP Name | | | | | | Organisation: | | | Organisation | | |
|  | | | | | | | | | | | | |
| Type: | OT | PT | SP | | POD | | | RN | Other, Please specify. | | | |
|  | | | | | | | | | | | | |
| Phone Number: | HP Phone | | | Email: | | HP Email | | | | | Date of Ax: |  |

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| **Recommendation** | | | |
| *Indigo may swap the recommended product for a similar product, depending on costs and availability. We will notify you prior to this occurring.* | | | |
| Qty | Item | Specifications  (Item Code/Model/Colour) | Supplier/ Link to item web page |
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| Please provide **clinical justification** below if it is anticipated **the total value is greater than $700 and/or an individual item recommendation is above the standard quantity or level of equipment.** |
| Clinical Justification |

**Delivery Details**

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| Deliver to:  Customer’s home  Health professional >> (at)  Please specify address:. | OR  Item has been left in situ\* >>  Reimbursement to supplier  Replace health professional’s stock >> (at) Please specify address:. |
| ***Note:*** *While we endeavour to replace the item left in situ, we are unable to guarantee this.* | |

**Submission Checklist**

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| **For faster review and more efficient outcomes for your client, please confirm:**  This person (the Customer) has sufficient cognitive and physical function to use recommended item/s.  The Customer, or their representative has given consent for this request to be made.  A health professional has/will provide or arrange for item set-up/review and training.  A referral or a support plan review (SPR) request to My Aged Care for Goods, Equipment and Assistive Technology services has been initiated or is already in place. Health professionals can make a referral with My Aged Care via their website. <https://www.myagedcare.gov.au/make-a-referral> |
| **Before your client can access any government-funded aged care services, they must be registered with My Aged Care.**  **Indigo cannot progress this request until a referral from My Aged Care for Goods, Equipment and Assistive Technology services has been received.**  **If your request is incomplete, Indigo will contact you to confirm the information provided.** |

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| Please read this information carefully, fill in the applicable boxes and sign below.  If the customer is unable to sign this form due to physical or cognitive decline, an appropriate third party may authorise this section on their behalf.  **Collection & Privacy Statement**  We collect your information for the primary purpose of providing Indigo services to enable you greater independence and inclusion through allied health and assistive technology solutions. With your consent, your details will be added to our client management system and will only be accessed for the purpose for which they were collected and by those involved in providing your service. You may choose someone to liaise with us about your services on your behalf by providing us with their contact details. We will only share your information with our suppliers, funders, health practitioners or other relevant providers as part of providing that service. You can withdraw or amend your consent at any time and can request to access and seek correction to the information which Indigo holds about you.  **Fees**  The Commonwealth Government subsidises aged care services, however customers are also expected to contribute to the cost of their services where they have the capacity to do so. Customers will be informed of their contribution amount at the time the service is arranged, or as soon as a quote is calculated and available. Contributions must be paid upfront before equipment items can be ordered. Capacity is assessed on a 1:1 basis in exceptional circumstances. Please contact us directly should you need to discuss your fees further.  **Eligibility**  You must first be registered with My Aged Care to access Government funded aged care services. Indigo cannot progress this request until a referral from My Aged Care for CHSP Goods, Equipment and Assistive Technology services has been received.  *For further information, you may access our* [*Privacy Policy*](https://www.indigosolutions.org.au/legal/privacy-policy) *and CHSP Customer Contribution Policy on the Indigo website or by contacting our Intake team.* |

**Customer Agreement**

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| --- | --- | --- | --- | --- | --- | --- |
| **Declaration** | | | | | | |
| Do you give consent to us recording your information? | | | | Yes  No | | |
|  | | | | | | |
| Do you consent for us to liaise with someone else on your behalf? | | | | Yes  No | | |
| If so, please state their details below: | | | | | | |
| Full Name: | Name of Liaison. | Relationship to you: | Relationship. | | Phone  Number: | Phone2. |
| I understand that I can withdraw my consent at any time, however, understand that this could impact my service delivery.  I have been involved in the prescription of equipment items and to the best of my knowledge agree that they will meet my needs.  I understand that where possible I will contribute financially to the cost of my equipment. This amount will be confirmed by Indigo prior to equipment being ordered and supplied. | | | | | | |

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| **Customer name:** | Name. | **Date:** | Date. |

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| **Signed:** |  |

**Third Party Authority on behalf of Customer** (only complete if relevant)

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| Reason for customer incapacity or inability to sign: | | |
| Reason. | | |
|  | | |
| **Consent given by authorised representative** | **OR** | **Informed consent or agreement** **obtained** |
| Name of authorised representative: |  | by (name of health professional): |
| Representative Name. |  | HP Name if required. |
| Relationship to customer: |  | via (method of collection): |
| Relationship to customer. |  | *e.g. video call, in person*  Method of colection. |
|  |  | and customer answered “yes” or “no” to above questions by: |
|  |  | *e.g. nodding or shaking head, saying yes or no*  Method of answering. |
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| --- | --- | --- | --- |
| **Date:** | Signature Date. | **Contact Number:** | Contact Number |

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| **Signed:** |  |