Australian Government
Services Australia

Australian Thalidomide Survivors Support Program Extraordinary Assistance Fund

When to use this form

Use this form to apply for:

- pre-approval of a quote(s) for goods or services yet to be received, or
- reimbursement of an invoice(s) for goods or services received

that are covered by the Extraordinary Assistance Fund (EAF). To read the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines*, go to **health.gov.au**

To claim for the EAF, you must:

- be an Australian citizen or a permanent resident and have current Medicare entitlement
- be registered with the Australian Thalidomide Survivors Support Program
- provide evidence from a registered health care practitioner that the goods or services are required as a likely consequence of thalidomide related injuries, and
- have already claimed from the National Disability Insurance Scheme (NDIS) or other relevant Australian, state or territory government scheme, or private insurance, where appropriate.

If you want to claim out-of-pocket health care expenses, you will need to complete the **Australian Thalidomide Survivors Support Program Health Care Assistance Fund (PB300)** form. To download the form, go to **servicesaustralia.gov.au/forms** or email **thalidomide.claims@servicesaustralia.gov.au** There may be risks with sending personal information through unsecured networks.

Online account

You can upload this form, with any supporting documents, using your **Medicare online account** through myGov. Sign in to **my.gov.au** and go to **Services**, then select **Medicare**.

If you do not have a myGov account, go to **my.gov.au** and create one. For help, go to **servicesaustralia.gov.au/onlineguides**

What else you will need to provide

Health care practitioner evidence

You must provide written evidence from a registered health care practitioner with this claim. This evidence should include the:

- health care practitioner's details, including their name, address and provider number
- date you were assessed by the registered health care practitioner
- type of goods or services needed, including the frequency and duration of the service (if applicable)
- goods or services recommended as a likely consequence of your thalidomide related injuries.

For more information

Go to **servicesaustralia.gov.au/thalidomide** or call the Thalidomide Support Service on 1800 643 787 Monday to Friday, 8 am to 5 pm, Australian Eastern Standard Time.

Information in your language

We can translate documents you need for your claim or payment for free.

To speak to us in your language, call **131 202**.

Hearing and speech assistance

If you have a hearing or speech impairment, you can use:

- the National Relay Service **1800 555 660**, or
- our TTY service on **1800 810 586**. You need a TTY phone to use this service.

For more information about help with communication, go to **servicesaustralia.gov.au** and search 'other support and advice'.

Australian Government
Services Australia

Australian Thalidomide Survivors Support Program
Extraordinary Assistance Fund (PB299)

Filling in this form

You can complete this form on your computer using Adobe Acrobat Reader, or you can print it.

For help on how to fill in our forms, go to **servicesaustralia.gov.au/formhelp**

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this ☐ ***Go to 1*** skip to the question number shown.

Claimant's details

1 Medicare card number

Ref no.

2 Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other

Family name

First given name

3 Has your postal address changed since your last claim?

No ☐ *Go to next question*

Not sure ☐ Give details below

Yes ☐ Give details below

We will use this to update your Medicare records.

Postal address

Postcode

4 Home phone number (including area code)

Mobile phone number

Email

Authorised representative

5 **Read** this before answering the following questions.

These questions tell us if you have authorised or would like to authorise a person to complete EAF claim forms or talk to staff about your EAF claim(s) on your behalf.

This does **not** authorise the nominated person to change your contact details.

From the date this form is submitted, the person you nominate below will be authorised to complete EAF claim forms or talk to staff about your claim(s) on your behalf.

Only one person can be nominated at a time.

You can still deal with us, even if you have authorised a person to help you.

If you want to change these details or if you think the access you have given a person is being misused, email **thalidomide.claims@servicesaustralia.gov.au**

There may be risks with sending personal information through unsecured networks or email channels.

Have you authorised a person to complete EAF claim forms or talk to staff about your claim(s) on your behalf?

No ☐ *Go to next question*

Yes ☐ ***Go to 7***

6 Do you want to authorise a person to complete EAF claim forms or talk to staff about your claim(s) on your behalf?

No ☐ *Go to next question*

Yes ☐ Give details below

Details of your authorised representative

Family name

First given name

Date of birth (DD MM YYYY)

Postal address

Postcode

Home phone number (including area code)

Work phone number (including area code)

Mobile phone number

What is the relationship of the authorised representative to you?

Tick one only

Carer ☐

Family member ☐

Power of attorney ☐

Other ☐ Give details below

Details of the goods or services

7 What is this claim for?

Tick all that apply

Pre-approval of a quote for goods or services ☐ ***Go to 8 on page 4***

Reimbursement for goods or services you received and paid, or part paid, for ☐ ***Go to 9 on page 6***

Pre-approval of quote for goods or services

Read this before answering the following questions.

When your claim has been assessed and approved, you will receive a letter with a pre-approval reference number. Once the goods or services have been received, return the letter with your invoice(s) or receipt(s) so payment can be made.

8 Are you seeking **pre-approval of a quote** for goods or services that you have **not yet received or paid for**?

No ☐ ***Go to 9***

Yes ☐ Give details below

If you are seeking more than 2 pre-approvals, copy this page for each extra request or provide a separate sheet with details.

Pre-approval 1 Goods or services **quoted**

8A What goods or services do you need pre-approval for?

Tick one only

- Assistance with daily living – service and support ☐
- Assistive technology – household aids and appliances ☐
- Assistive technology – assistive products for household tasks ☐
- Assistive technology – personal aids and appliances ☐
- Assistive technology – safety devices ☐
- Home modifications ☐
- Vehicle modifications ☐
- Respite care ☐
- Other ☐ Give details below

Description of goods or services

Pre-approval 1 *Continued*

8B I am seeking pre-approval of the quote from:

Name of person or business

Contact phone number for person or business (including area code)

ABN for person or business

Date of quote (DD MM YYYY)

Value of quote

$

8C If you have received more than one quote, tell us below why you have selected this quote (for example, price, describe value for money, provides a specific service).

Provide copies of all quotes received with your claim.

8D Do you want pre-approval of a quote for other goods or services?

No ☐ ***Go to 8E***

Yes ☐ ***Go to Pre-approval 2 – 8A***

8E Do you want to claim for reimbursement of goods or services received?

No ☐ ***Go to 12***

Yes ☐ ***Go to 9 on page 6***

Pre-approval 2 Goods or services **quoted**

8A What goods or services do you need pre-approval for?

Tick one only

- Assistance with daily living – service and support ☐
- Assistive technology – household aids and appliances ☐
- Assistive technology – assistive products for household tasks ☐
- Assistive technology – personal aids and appliances ☐
- Assistive technology – safety devices ☐
- Home modifications ☐
- Vehicle modifications ☐
- Respite care ☐
- Other ☐ Give details below

Description of goods or services

8B I am seeking pre-approval of the quote from:

Name of person or business

Contact phone number for person or business (including area code)

ABN for person or business

Date of quote (DD MM YYYY)

Value of quote

$

8C If you have received more than one quote, tell us below why you have selected this quote (for example, price, describe value for money, provides a specific service).

Provide copies of all quotes received with your claim.

Pre-approval 2 *Continued*

8D Do you want pre-approval of a quote for other goods or services?

No ☐ ***Go to 8E***

Yes ☐ ***Go to 8E***

8E Do you want to claim for reimbursement of goods or services received?

No ☐ ***Go to 12***

Yes ☐ ***Go to 9 on page 6***

If you need more space, provide a separate sheet with details.

Bank details

9 Do you want your reimbursement for goods or services received to be made to the same account you receive your Medicare payments?

No ☐ *Go to next question*

Yes ☐ ***Go to 11A***

10 Where do you want your payments for claims to the EAF made?

Any bank details provided in this form will result in all Medicare payments being paid to this account.

All payments are made through electronic funds transfer (EFT). Payments **cannot** be made via EFT if the nominated account has restrictions on EFT deposits.

Payments cannot be made to an account used exclusively for funding from the NDIS.

Name of bank, building society or credit union

Branch number (BSB)

Account number (this may not be your card number)

Account held in the name(s) of

Read this before answering the following questions.

If you have more than 2 claims, copy this page for each additional claim or provide a separate sheet with details.

Claim 1 **Reimbursement** for goods or services **received**

11A Do you have a pre-approval number for the goods or services you are claiming?

No ☐ ***Go to 11B***

Yes ☐ Pre-approval number

Go to 11D

11B What goods or services have you **received**?
Tick one only

Assistance with daily living – service and support ☐

Assistive technology – household aids and appliances ☐

Assistive technology – assistive products for household tasks ☐

Assistive technology – personal aids and appliances ☐

Assistive technology – safety devices ☐

Home modifications ☐

Vehicle modifications ☐

Respite care ☐

Other ☐ Give details below

Description of goods or services received

Date you received the goods or services

(DD MM YYYY)

Total cost of the goods or services you received

$

11C Who provided the goods or services?

Name of person or business

Contact phone number for person or business (including area code)

ABN for person or business

Claim 1 *Continued*

11D Have you received any reimbursement or payments for the goods or services you are claiming?

No ☐ ***Go to 11E***

Yes ☐ Give details below

NDIS	$
Medicare	$
Private health fund	$
Any other relevant Australian, state or territory government scheme	$
Other, give details below	
	$
	$
	$

11E Amount you are claiming from the EAF for the goods or services received after any reimbursements (if applicable)

$

Provide copies of tax invoices or receipts with your claim.

11F Do you want to claim for another reimbursement?

No ☐ ***Go to 12***

Yes ☐ ***Go to Claim 2 – 11A***

Claim 2 **Reimbursement** for goods or services **received**

11A Do you have a pre-approval number for the goods or services you are claiming?

No ☐ ***Go to 11B***

Yes ☐ Pre-approval number

Go to 11D

11B What goods or services have you **received**?
Tick one only

- Assistance with daily living – service and support ☐
- Assistive technology – household aids and appliances ☐
- Assistive technology – assistive products for household tasks ☐
- Assistive technology – personal aids and appliances ☐
- Assistive technology – safety devices ☐
- Home modifications ☐
- Vehicle modifications ☐
- Respite care ☐
- Other ☐ Give details below

Description of goods or services received

Date you received the goods or services

(DD MM YYYY)

Total cost of the goods or services you received

$

11C Who provided the goods or services?

Name of person or business

Contact phone number for person or business (including area code)

ABN for person or business

Claim 2 *Continued*

11D Have you received any reimbursement or payments for the goods or services you are claiming?

No ☐ ***Go to 11E***

Yes ☐ Give details below

NDIS	$
Medicare	$
Private health fund	$
Any other relevant Australian, state or territory government scheme	$
Other, give details below	
	$
	$
	$

11E Amount you are claiming from the EAF for the goods or services received after any reimbursements (if applicable)

$

Provide copies of tax invoices or receipts with your claim.

11F Do you want to claim for another reimbursement?

No ☐

Yes ☐

If you need more space, provide a separate sheet with details.

12 Who completed this form?

Tick all that apply

Claimant ☐ ▶ As the claimant, you are to sign at **question 15**

▶ *Go to next question*

Authorised representative ☐ ▶ As the authorised representative, you are to sign at **question 16**

Provide supporting documentation that demonstrates the authority. For example, power of attorney or appropriate medical evidence from a registered health care practitioner.

▶ *Go to next question*

Checklist

13 Which of the following documents are you providing with this form?

Where you are asked to supply documents, provide original documents. In some circumstances, copies may be accepted as detailed in the below checklist.

If you are not sure, check the question to see if you should provide the documents.

Evidence from a registered health care practitioner (mandatory) (see **Health care practitioner evidence** on page 1)	☐
Copies of all quotes for goods or services – for pre-approval documentation requirements, refer to the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines* (If required at **question 8C**)	☐
Copies of receipts or tax invoices (If required at **question 11E**)	☐
Supporting documentation that demonstrates the authority. For example, power of attorney or appropriate medical evidence from a registered health care practitioner (If required at **question 12**)	☐

Privacy notice

14 The privacy and security of your personal information is important to us, and is protected by law. We collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to **servicesaustralia.gov.au/privacypolicy**

▶ **Questions continue**

Claimant's declaration

15 I declare that:

- I am registered and eligible to receive help under the Australian Thalidomide Survivors Support Program
- I am the recipient of the goods or services being claimed
- the goods or services being claimed are required as a likely consequence of my thalidomide related injury(ies), covered by the Australian Thalidomide Survivors Support Program as outlined in the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines*
- all other entitlements and benefits, for example, private health fund, Medicare, National Disability Insurance Scheme or other government support, have been claimed where possible
- all out-of-pocket expenses claimed by me relate to goods or services for which I am entitled to claim a payment under the Australian Thalidomide Survivors Support Program
- the information I have provided in this form is complete and correct.

I understand that:

- benefits are provided under the Australian Thalidomide Survivors Support Program as a result of information that I have provided
- a random audit of claims made to the Extraordinary Assistance Fund will be undertaken
- I am required to keep copies of relevant records for a minimum of 5 years for auditing purposes
- giving false or misleading information is a serious offence and may result in Services Australia recovering benefits provided by the Australian Thalidomide Survivors Support Program.

I consent to:

- Services Australia collecting, using and disclosing information about me (including my Medicare information) to:
  - verify if I have claimed or received other entitlements and benefits (including private health fund, Medicare, National Disability Insurance Scheme or other government support)
  - verify information provided by a third party for the purposes of assessing my claim under the Australian Thalidomide Survivors Support Program.

Claimant's signature

Date (DD MM YYYY)

Authorised representative's declaration

16 Authorised representative acceptance

I declare that:

- the claimant is registered and eligible to receive help under the Australian Thalidomide Survivors Support Program
- the claimant is the recipient of the goods or services being claimed
- the goods or services being claimed are required as a likely consequence of the claimant's thalidomide related injury(ies), covered by the Australian Thalidomide Survivors Support Program as outlined in the *Extraordinary Assistance Fund (EAF) and Health Care Assistance Fund (HCAF) Program Guidelines*
- all other entitlements and benefits, for example, private health fund, Medicare, National Disability Insurance Scheme or other government support, have been claimed by the claimant where possible
- all out-of-pocket expenses claimed by the claimant relate to goods or services for which the claimant is entitled to claim a payment under the Australian Thalidomide Survivors Support Program
- I understand and accept the responsibilities and obligations to act on behalf of and in the best interests of the claimant
- the information I have provided in this form is complete and correct.

I understand that:

- any personal information I am given access to under this type of access is protected under Commonwealth legislation. I agree to access, use or disclose the information only as authorised by the person to whom the information relates
- benefits are provided under the Australian Thalidomide Survivors Support Program as a result of information that I have provided
- a random audit of claims made to the Extraordinary Assistance Fund will be undertaken
- I am required to keep copies of relevant records for a minimum of 5 years for auditing purposes
- giving false or misleading information is a serious offence and may result in Services Australia recovering benefits provided by the Australian Thalidomide Survivors Support Program.

Name of authorised representative

Authorised representative's signature

Date (DD MM YYYY)

Returning this form

Check all required questions are answered and that the form is signed and dated.

Return this form and all supporting documents:

- **online** using your Medicare online account through myGov.
- by email to **thalidomide.claims@servicesaustralia.gov.au** There may be risks with sending personal information through unsecured networks or email channels.
- by post to Services Australia, Australian Thalidomide Survivors Support Program, PO Box 9822, In your capital city

Clear