



**Australian Government**  
**Department of Social Services**



# **Contingence 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:

Continence Aids Payment Scheme  
Medicare  
GPO Box 9822  
Sydney NSW 2001

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.

### 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
- 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
- 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 and Ageing (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](http://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
- 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 and Ageing, 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 **132 011**, select general enquiries. For more information about the CAPS call the National Continence Helpline on **1800 330 066** or go to [www.bladderbowel.gov.au](http://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 five 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

If the answer is **No** to both **E1** and **E2**, then the applicant is not eligible for assistance from CAPS. Refer to CAPS application guidelines.

- 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 Extended Aged Care at Home (EACH) or EACH Dementia (EACHD) 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.

## 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 address

State

Postcode

Medicare may update the applicant's Medicare address if the person signing the declaration on this form is the applicant, the applicant's parent or the applicant's legal representative. Updating the Medicare card address will update the address of all persons listed on the Medicare card.

**A7** Who will be signing the applicant declaration or representative declaration section of this form (see A23/R13)? (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 dependent 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:

**A13** Does the applicant receive assistance from any of the following?

Community Aged Care Package

Low level Australian Government funded aged care home

Home and Community Care Program

National Respite for Carers Program

### Correspondence recipient

CAPS correspondence may be directed to a person other than the applicant, including to a family member or carer of the applicant. A correspondence recipient will receive all of the applicant's CAPS correspondence, including the payment statement. If the applicant has a payment representative the payment representative will also receive a payment statement.

**A14** Is a person other than the applicant to receive the correspondence?

Yes  **Go to A15**

No  **Go to A19**

**A15** 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

*question continues next page...*

- 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:

**A16** Family name of correspondence recipient

First given name of correspondence recipient

**A17** Correspondence recipient's address  
  
  
  
State  Postcode

**A18** Correspondence recipient's daytime contact number  
 (  )

## Payment Details

**A19** 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

**A20** 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 A22
- No  Go to A21

### A21 Applicant's nominated bank account details

Medicare will update the applicant's bank account details on Medicare records with the bank details provided below if the person signing the **Applicant's declaration (A23)** or the **Representative's declaration (R13)** sections of this form is the applicant or the applicant's parent, legal guardian or a Power of Attorney.

The account recorded must be an Australian bank account.

Payments cannot be made into credit cards, loan or mortgage accounts.

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

**A22** Is a person other than the applicant signing the declaration on this form?

- Yes  Go to Section 2 – Representative details.
- No  Go to A23

### A23 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;
- 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;
- the CAPS payment provided is for the purchase of continence products.

Signature

Date  
 /  /   
dd mm yyyy

### Privacy Note

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

**A24** 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 DETAILS

This section must be completed where either:

- a) a person other than the applicant is to sign the *Representative's declaration* section of this form (see *Who can complete this form?* on page 1); or
- b) a person other than the applicant is to receive a CAPS payment (see *Who can receive payments?* on page 1).

Documentary evidence of that person's authority to act on behalf of the applicant/receive a payment on behalf of the applicant must be provided with this form.

Documentary evidence includes:

For a parent of an applicant:

- Signing of the declaration section of this form (for a child under 14 years of age or for a child 14 –17 years if they do not have the capacity to act on their own behalf.)

For a legal representative:

- Guardianship papers;
- Power of Attorney or Enduring Power of Attorney documents;
- Court appointment documents; or
- Other legal documentation, as applicable.

*Certified copies of legal documents are to be provided. Do not send original documents. A certified copy is a copy of an original document that has been certified as a true and correct copy by a person authorised to witness a statutory declaration, for example a medical practitioner, a pharmacist or a public servant.*

For a Centrelink Payment Nominee, documents (valid within the last 12 months) which prove your nominee status, for example:

- a Centrelink Nominee Appointment letter.

For a Centrelink Correspondence Nominee, documents (valid within the last 12 months) which prove your nominee status, for example:

- Centrelink Payment Summary or Centrelink Account Statement that displays the name and address of the nominee and the name of the applicant;
- a Centrelink Nominee Appointment letter.

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

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
State	Postcode

**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

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
State	Postcode

**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;
- 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;
- 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

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

**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

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
State	Postcode

**R22** Organisation's postal address

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	
State	Postcode

### 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;
- 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);
- 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

<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
dd		mm		yyyy

### Privacy Note

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

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

## SECTION 3 – HEALTH REPORT

### 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](http://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

  
  
  
State  Postcode 

**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** Does the applicant have *permanent and severe* incontinence caused by an eligible *Neurological* condition?

No

Yes  Specify Neurological condition

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

No

Yes  Specify other condition

If the answer to both **H8** and **H9** is **No** please refer to CAPS application guidelines as applicant is not eligible.

**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

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

question continues next page...



**[www.health.gov.au](http://www.health.gov.au)**

All information in this publications is correct as at January 2012.