Thermoregulatory Dysfunction Energy Subsidy Scheme
Application Form

Further information

PATIENT

First Name: ____________________________________________
Middle Name(s): ______________________________________
Surname: _____________________________________________
Date of Birth: __________/________/________

GUARDIAN / PRIMARY CAREGIVER

Only complete this section if the patient is unable to sign or does not hold a valid concession card. The guardian / caregiver must reside with the patient.

First Name: ____________________________________________
Middle Name(s): ______________________________________
Surname: _____________________________________________
Date of Birth: __________/________/________
Relationship to patient: __________________________________

CONCESSION CARD DETAILS

Type of card: ☐ Pensioner Concession Card
☐ Health Care Card (does not include a Commonwealth Seniors Health Card)
☐ Health Care Interim Voucher

Card number: __________________________________________
Name on card: __________________________________________

OFFICE USE ONLY

Application ID
CONTACT DETAILS

Email Address: .................................................................

Phone Number: .................................................................

Home Address: .................................................................
Where the energy consumption is being used .................................................................

Postcode  ________________

Postal Address: .................................................................
If same as home address write ‘As above’ .................................................................

Postcode  ________________

Whose details are these? [ ] Patient  [ ] Guardian / Caregiver

BANK ACCOUNT DETAILS

Must be a Savings or Cheque Account. The subsidy will be paid to this account.

Bank or Financial Institution (e.g. ANZ) .................................................................

Branch of Bank (e.g. Innaloo) .................................................................

BSB Number (6 digits) .................................................................

Account Number (up to 9 digits) .................................................................

Name of the account holder (as it appears on the bank statement) .................................................................
AUTHORISATION AND DECLARATION

Read, sign and date the authorisation and declaration.

I authorise –

- RevenueWA to use Centrelink Confirmation eServices to perform a Centrelink/DVA enquiry of my Centrelink or Department of Veterans’ Affairs Customer details and concession card status in order to enable the business to determine if I qualify for a subsidy.
- the Australian Government Services Australia to provide the results of that enquiry to RevenueWA.
- RevenueWA to contact the medical practitioner who signed this form to confirm or seek additional information on my application.

I understand that –

- Services Australia will use information I have provided to RevenueWA to confirm my eligibility for the subsidy and will disclose to RevenueWA personal information including my name, address, payment and concession card type and status.
- this consent, once signed, remains valid while I am a customer of RevenueWA unless I withdraw it by contacting RevenueWA or Services Australia.
- I can obtain proof of my circumstances/details from Services Australia and provide it to RevenueWA so that my eligibility for the subsidy can be determined.
- if I withdraw my consent or do not alternatively provide proof of my circumstances/details, I may not be eligible for the subsidy provided by RevenueWA.

I hereby declare that –

- this subsidy is to offset the cost of energy associated with temperature control for myself, or my dependant, at the address shown on page one.
- I am not currently claiming a Thermoregulatory Dysfunction Energy Subsidy for myself, or my dependant, at another address.
- I will notify RevenueWA in writing of any changes that affect either the validity of this application or my entitlement to the concession card.
- I authorise payment of the subsidy into the bank account as detailed on this form.
- I understand that Energy Policy WA will conduct a review of subsidy recipients on a regular basis. To obtain the subsidy I hereby authorise the release of my medical records to Energy Policy WA for the purposes of review. If I receive a subsidy on the basis of incorrect information I will be required to repay any subsidy paid.
- all particulars in this form are, to the best of my knowledge and belief, true and accurate.

Who is signing this declaration?  

☐ Patient  ☐ Guardian / Caregiver

If the Guardian / Caregiver is signing, their details must also be written on the first page of this form.

Full Name:  

______________________________

Signature:  

______________________________

Date:  

_____/_____/_______

THE FOLLOWING PAGES MUST BE COMPLETED BY A GENERAL PRACTITIONER OR SPECIALIST MEDICAL PRACTITIONER.
MEDICAL AUTHORISATION – DOCTOR TO COMPLETE

These pages must be completed by a general practitioner or specialist medical practitioner

Thermoregulatory dysfunction is defined as a significant loss of a person’s capacity to control body temperature when exposed to extremes of environmental temperatures. This results in the affected person being at risk of serious detriment to their general health and bodily function.

The following conditions are excluded from the scheme as they do not affect an individual’s capacity to regulate internal body temperature:

- Attention Deficit Hyperactive Disorder
- autism and
- psychiatric conditions such as anxiety, depression and obsessive-compulsive disorder.

Name of condition causing thermoregulatory dysfunction

e.g. Multiple sclerosis, stroke, burns

To qualify for the subsidy, the patient must

- be certified by a doctor who has been the patient’s treating doctor for at least three months and
- be assessed as meeting two of the three qualifying criteria.

<table>
<thead>
<tr>
<th>Qualifying Criteria</th>
<th>Tick if assessed</th>
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<tr>
<td>1. <strong>Autonomic system dysfunction.</strong></td>
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<tr>
<td>Medical condition with an evidence-based association with the deterioration of this condition in temperature extremes. For example, severe cases of spinal cord injury, stroke, brain injury, neurodegenerative disorders, multiple sclerosis and familial disautonomia.</td>
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<td>2. <strong>Loss of skin integrity or loss of sweating capacity.</strong></td>
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<td>For example, significant burns of greater than 20% of body surface area, severe inflammatory skin conditions and some rare forms of disordered sweating.</td>
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<td>3. <strong>Objective reduction of autonomic regulation and physiological functioning at extremes of environmental temperatures.</strong></td>
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<td>For example, excessive sweating, heart rate increases or changes in blood pressure resulting in dehydration, dizziness or fainting.</td>
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Is the condition permanent?  

[ ] Yes  [ ] No

The condition is permanent if the patient has

- severe autonomic dysfunction, specifically
  - high spinal transection
  - familial disautonomia or
  - progressive neuro-genetic degenerative conditions.

or

- extensive loss of skin integrity, with burns to over 50 per cent of the body surface area.

Provide a copy of the medical report confirming the condition and stating that it is a permanent condition.

If the medical report is not provided with this application, eligibility for the subsidy will be reviewed after 12 months.
I certify that I have been the treating doctor of ________________________________(full name of patient) for at least three months and I have provided accurate information about the patient’s condition.

I have sighted the following documentation regarding the diagnosis.

☐ Specialist Report
☐ Hospital Discharge Summary

I hereby acknowledge the applicant/patient’s consent to allow Energy Policy WA to access the medical records for the purposes of reviewing and auditing the subsidy and will cooperate in making the records available.

Signature of doctor: _______________________________ Date: ___ / ___ / ___

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<thead>
<tr>
<th>Doctor’s Surname:</th>
<th>Provider Number:</th>
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<tr>
<td>Doctor’s Given Name:</td>
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<tr>
<td>Postal Address:</td>
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<td>Email Address:</td>
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<td>Phone Number:</td>
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Add Stamp (if available)

HOW TO LODGE THIS FORM

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<tr>
<td>BY POST</td>
<td>RevenueWA, GPO Box T1600, Perth WA 6845</td>
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