Part A: APPLICANT DETAILS

If you are an Australian citizen or permanent resident 21 years or older and you meet one of the following, you are eligible for a Hearing Services Voucher

YOUR ELIGIBILITY TYPE (Tick the relevant box)

- ☐ Centrelink Pensioner Concession Card (PCC)
- ☐ Centrelink Sickness Allowance
- ☐ DVA Pensioner Concession Card
- ☐ White Health Repatriation Card (for hearing loss)
- ☐ Gold Health Repatriation Card
- ☐ Are a member of the Australian Defence Forces
- ☐ Other (refer overleaf)

YOUR ELIGIBILITY NUMBER (Write in your number e.g. your PCC number starting with CRN, or your DVA file number starting with NX etc.)

Title | Last Name (Please Print)

First Name | Middle Name

Sex (M/F) | Date of birth

Postal Address

State | Post Code

Telephone Number

( )

CERTIFICATION BY APPLICANT

The Office of Hearing Services (OHS) uses your relevant personal information for the administration and delivery of the OHS program which includes verifying your eligibility from time to time. Accordingly it is usual practice for OHS to disclose to and receive relevant personal information about you from Centrelink, the Department of Veterans' Affairs and the Department of Defence. The administration and clinical delivery of the OHS program may also require OHS, your hearing service provider and your medical practitioner to disclose and receive relevant personal information about you between each other. The OHS and service provider may also provide information about your hearing service to Medicare Australia for payment purposes. By signing below you indicate to us that you

(i) understand the above uses and disclosures and
(ii) consent to them.

Applicant/Authorised Person's Signature **Date**

/ /

If the applicant is unable to sign, a responsible person can sign on their behalf. If you are signing on someone's behalf, please advise your relationship to them.

Relationship of Signer to Applicant

ALTERNATIVE CONTACT (Optional)

If you wish to nominate a friend or family member as an alternative contact, please provide the details below.

Their Name

Their Telephone Number

( )

Part B: REFERRAL DETAILS

A doctor must complete this part

DETAILS OF MEDICAL PRACTITIONER

Title | Name (Please Print)

Medicare Provider Number

Postal Address

State | Post Code

Telephone Number

( )

CERTIFICATION BY MEDICAL PRACTITIONER

I have examined this patient and (tick as appropriate):

- ☐ I am satisfied that they can be referred for a hearing assessment and, where clinically appropriate, rehabilitation services.

AND

- ☐ I am satisfied that there are no medical contraindications to the fitting of a hearing device.

OR

- ☐ I consider that there are medical contraindications to the fitting of a hearing device.

Medical Practitioner's Signature **Date**

/ /

Part C: OTHER ELIGIBILITY

You are also eligible to apply for a Hearing Services Voucher if you are in one of the two following categories. Please tick the relevant category.

- ☐ Partner (including married, de-facto or same sex partner) of an eligible person (not including a member of the Australian Defence Force).
- ☐ Dependant child of an eligible person (not including a member of the Australian Defence Force) who is 21 or over and under 25 years and who is undertaking full time study.

Eligibility Number of Eligible Partner or Parent

(Write in THEIR number e.g. their PCC number starting with CRN, or their DVA file number starting with NX etc.)

Name of Eligible Partner or Parent

Part D: ADDITIONAL INFORMATION

The following information is used for planning and reporting purposes or to assist in communicating with you. Your response is optional, but your assistance would be appreciated.

Is English your first language?

- ☐ Yes
- ☐ No, other (please specify)

Are you of Aboriginal or Torres Strait Islander origin?

- ☐ Yes, Aboriginal/Torres Strait Islander
- ☐ No

NOTIFICATION OF VOUCHER ISSUE

Would you like notification about your Voucher to be sent to another person for example the Director of Nursing if you live in an aged care home?

- ☐ Yes

Name of Person you want notified

Address of Person you want notified (if different to your address)

State Post Code

- ☐ No

Please post the completed form to the address below, NOT your Service Provider.

To: Applications
Mail Drop Point 113
Office of Hearing Services
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

FOR MORE INFORMATION CONTACT:

1800 500 726 or **(TTY) 1800 500 496**
email: **hearing@health.gov.au**
DVA Clients can ring 1800 637 816
Or visit the Office of Hearing Services Website at:
www.health.gov.au/hear

Australian Government
Department of Health and Ageing
Office of Hearing Services

Application for a Hearing Services Voucher for NEW CLIENTS

DO NOT COMPLETE THIS FORM IF YOU HAVE PREVIOUSLY RECEIVED A VOUCHER

www.health.gov.au/hear
email: hearing@health.gov.au

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