**Please read this form and if you have any questions call the Lifetime Care and Support Authority (Lifetime Care) on 1300 738 586 or visit** [www.icare.nsw.gov.au](http://www.icare.nsw.gov.au/)**. Lifetime Care is a service line in Insurance & Care NSW (icare).**

Please provide as much information as you can. If you don’t know an answer you can write “not known” in the box.

## National Relay Service

Callers who are deaf or have a hearing or speech impairment can call through the National Relay Service:

* TTY/voice calls: phone 133 677 and quote 1300 738 586
* Speak and Listen calls: Phone 1300 555 727 and quote 1300 738 586

## Do you need an interpreter?

Please call Associated Translators and
Linguists Pty Ltd on (02) 9231 3288
between 8:30 and 5pm Monday to Friday

## The Lifetime Care and Support Scheme

This form is to provide early notification to Lifetime Care about a person’s severe injuries that may make them eligible to become an interim participant in the Lifetime Care and Support Scheme (the Scheme), under the Motor Accidents (Lifetime Care and Support) Act 2006.

Lifetime Care pays for reasonable and necessary treatment, rehabilitation and care services for participants in the Scheme. Providing early notification means that we can appoint a Lifetime Care contact to provide more information about applying for the Scheme.

Adults (being persons aged 16 years or over) who have been severely injured in a motor accident in NSW from 1 October 2007 onwards may be eligible for the Scheme. Children aged under 16 years that have been severely injured in a motor accident in NSW from 1 October 2006 may also be eligible.

To be eligible, one of the following severe injuries must have occurred as a result of a motor accident:

* brain injury
* spinal cord injury
* amputation/s
* burns
* permanent blindness.

## Who can complete this form?

* Parts 1, 2, 3 and 6 of this form are to be completed by an injured person, or a person responsible on their behalf. Where the injured person has impaired decision-making capacity or a disability that means they are unable to complete this form, written permission can be given on behalf of the injured person by a person responsible within the meaning of section 33A (4) of the Guardianship Act 1987, being a guardian, a spouse or partner, a carer or a close friend or relative (as defined in the Guardianship Act 1987).
* A Compulsory Third Party insurer can also complete this form on behalf of an injured person under section 8 of the Motor Accidents (Lifetime Care and Support) Act 2006 and doesn’t require the injured person’s consent to do so (however consent is recommended).
* Parts 4 and 7 need to be completed by a member of the treating health team.

## This form is being completed by

[ ]  Injured person or person responsible (see p1 "Who can complete this form?") on their behalf

[ ]  Medical/allied health professional

[ ]  CTP Insurer (complete the CTP insurer details on page 4 and attach copy of claim form)

|  |  |
| --- | --- |
| [ ]  Other: |       |

## What will happen next?

We’ll appoint a Lifetime Care contact who’ll find out more about your injuries and the accident, and give you more information about the Scheme, including the eligibility criteria. You’ll need to complete an **Interim Application Form** to apply for the Scheme and your treating team will need to assess your injury see if it meets the eligibility criteria.

## Your privacy

Your personal and health information will be managed in accordance with the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002. The information collected enables Lifetime Care to administer the Scheme and carry out the functions of the Lifetime Care and Support Authority under the Motor Accidents (Lifetime Care and Support) Act 2006.

## Compulsory Third Party Insurance (CTP)

This form is not a CTP Personal Injury Claim Form. You may also be able to make a claim
with a CTP insurer.

People whose injuries don’t meet the Scheme injury criteria may be eligible to have their
treatment, rehabilitation and care expenses paid for by the CTP insurer of the vehicle that
caused the injury.

Further information on making a CTP claim can be obtained by contacting the State Insurance Regulatory Authority (SIRA) CTP Assist on 1300 656 919 or email ctpassist@sira.nsw.gov.au.

### 1. Personal details of the injured person

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** |       | **Surname** |       | **First Name(s)** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of Birth** |       |  | **Gender**  [ ]  Male  [ ]  Female |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Street Address** |  | Suburb |  | State |  | Postcode |
|       |  |       |  |       |  |       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Postal Address (if different)** |  | Suburb |  | State |  | Postcode |
|       |  |       |  |       |  |       |

|  |  |  |
| --- | --- | --- |
| **Is an interpreter required?**  [ ]  No  [ ]  Yes | **Language** |       |

### 2. Personal details of person responsible (see page 1, "Who can complete this form?")

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Title** |       | **Surname** |       | **First Name(s)** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Relationship to injured person** |  | **Home phone** |  | **Work phone** |
|       |  |       |  |       |

|  |  |  |
| --- | --- | --- |
| **Mobile Phone** |  | **Email address** |
|       |  |       |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Street Address** |  | Suburb |  | State |  | Postcode |
|       |  |       |  |       |  |       |
| **Postal Address (if different)** |  | Suburb |  | State |  | Postcode |
|       |  |       |  |       |  |       |

|  |  |  |
| --- | --- | --- |
| **Is an interpreter required?**  [ ]  No  [ ]  Yes | **Language** |       |

|  |  |
| --- | --- |
| **Lifetime Care to contact:**  [ ]  Injured person [ ]  Person responsible [ ]  Other |       |

### 3. Accident details

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of accident** |  | **Time of accident** |  | **Street of Accident** |  | Suburb of accident |  | Postcode |
|       |  |       |  |       |  |       |  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Police station** |  | **Event number (if known)** |  | **Attending officer (if known)** |
|       |  |       |  |       |

**Injured person’s part in the accident:**

[ ]  Driver [ ]  Motorcycle rider [ ]  Pedestrian [ ]  Pillion passenger [ ]  Passenger [ ]  Cyclist [ ]  Other

|  |
| --- |
| **Main vehicle involved in the accident:** |
| Registration number plate |  | State |  | Make or model *(e.g. Toyota Camry)* |  | Type *(e.g. station wagon)* |
|       |  |       |  |       |  |       |

**Was the injured person travelling in this vehicle?  [ ]**Yes  [ ]  No

### 4. Nominated contact for treating health team

**Please identify a contact person from the treating team for ongoing communication with Lifetime Care (for example a social worker, clinical nurse consultant or case manager)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Full name** |       | **Position** |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Hospital or rehabilitation unit** |  | **Phone** |  | **Fax** |
|       |  |       |  |       |

|  |  |  |
| --- | --- | --- |
| **Mobile Phone** |  | **Email address** |
|       |  |       |

|  |
| --- |
| Mailing address |
| **Street**  |  | Suburb |  | State |  | Postcode |
|       |  |       |  |       |  |       |

### 5. CTP insurer notification

**If a CTP insurer is completing this form, please attach a copy of the CTP claim form, any relevant accident investigation reports, police reports and any other documents.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CTP Insurer’s name** |  | **CTP claim number** |  | **Insurer’s contact** |
|       |  |       |  |       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Phone** |  | **Fax** |  | **Address** |
|       |  |       |  |       |

|  |  |
| --- | --- |
| **Claim status** |       |

**Is the injured person, or their person responsible (see p1, "Who can complete this form?") aware of this application?  [ ]**Yes  [ ]  No

|  |  |  |
| --- | --- | --- |
| **Do they agree to this application? [ ]**Yes  [ ]  No | **Date CTP claim form received** |       |

### 6. Consent and declaration

Please read carefully before signing.

**This declaration must be signed by the injured person, or a person responsible (see p1, "Who can complete this form?"). The person who signs this form must be over 18.**

**Please note a CTP Insurer cannot authorise Lifetime Care to collect and share the injured person’s personal and health information without the injured person’s consent.**

I solemnly and sincerely declare that, to the best of my knowledge, the information given in this **Severe Injury Advice Form** is true and correct in every respect.

I authorise Lifetime Care to contact, obtain and share information and documents relevant to my/the injured person’s motor accident injury and my/the injured person’s treatment, rehabilitation and care needs with:

* My/the injured person’s family or guardian;
* the State Insurance Regulatory Authority (SIRA), a New South Wales government agency;
* an insurer carrying on the business of providing workers compensation, personal injury or CTP insurance;
* a department, agency or instrumentality of the Commonwealth, the State or another State or Territory;
* if you live or travel overseas, any private or government entity necessary to deliver treatment and care services to you or otherwise manage your participation in the Scheme;
* a hospital, including a private hospital;
* an ambulance, police department and/or other emergency services;
* a medical practitioner;
* a person who is qualified to assess the treatment, care and support needs of a person;
* a provider of treatment, care or support services including attendant care and support services;
* an employer or previous employer;
* an educational institution;
* any legal practitioner engaged in representing a party making a claim for compensation or damages (including personal injury, workers compensation or CTP).

I understand that information obtained under this declaration may include pre-accident and general medical information. I understand that this information will be used for the purposes explained on page 2 of this form.

|  |  |
| --- | --- |
| **Name of injured person** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature of injured person** |  | **Date** |       |

**Complete this section if you are a person responsible (see p1, "Who can complete this form?")**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |       | **Signature** |  |

|  |  |
| --- | --- |
| **Relationship to injured person** |       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Phone** |       | **Date** |       |

|  |  |
| --- | --- |
| **Reason why the injured person could not sign** |       |

### 7. Medical information

|  |  |
| --- | --- |
| **Name of injured person** |       |

#### Brain injury

[ ]  The duration of PTA is greater than 1 week.

OR

[ ]  There is evidence of a very significant impact to the head causing coma for longer than one hour.

OR

[ ]  There is significant brain imaging abnormality, e.g. penetrating injury.

AND

[ ]  The injured person is aged over 3 years and there is one FIM™ item scored 5 or less, (or 2 less than the age norm for WeeFIM®) **due to the brain injury**.

OR

[ ]  The injured person is a child under 3 years. The child will probably have permanent impairment **due to the brain injury** resulting in a significant adverse impact on their normal development.

|  |  |  |
| --- | --- | --- |
|  | Spinal cord injury (permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction) |  |
|  | Neurological (SCI) level: |       | ASIA impairment scale: |       |  |
|  |  |  |

#### Amputation/s

##### Multiple amputations (or equivalent impairment)

[ ]  Multiple amputations (or the equivalent impairment) of the upper and/or lower extremities

OR

##### Unilateral amputation (or equivalent impairment)

The amputation (or equivalent impairment) is one of the following:

[ ]  forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation

[ ]  hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy)

[ ]  hip disarticulation (complete amputation of the femur)

[ ]  short transfemoral amputation

[ ]  brachial plexus avulsion or rupture resulting in partial or total paralysis

[ ]  an equivalent impairment to any of the injuries described above

|  |  |
| --- | --- |
| **Name of injured person** |       |

#### Burns

[ ]  The injured person is a child under 16 years that has full thickness burns greater than 30% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.

OR

[ ]  The injured person is an adult that has full thickness burns greater than 40% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.

AND

[ ]  The injured person is aged over 3 years and there is one FIM™ item scored 5 or less, (or 2 less than the age norm for WeeFIM®) **due to the burns**.

OR

[ ]  The injured person is a child under 3 years. The child will probably have permanent impairment **due to the burns** resulting in a significant adverse impact on their normal development.

#### Permanent blindness

[ ]  The injured person has sustained permanent blindness and is legally blind

**Additional comments**

|  |
| --- |
|       |

|  |  |  |  |
| --- | --- | --- | --- |
| **Treating doctor’s name** |       | **Contact phone** |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Qualification** |       | **Provider Number** |       | **Date** |       |

## More information

Contact Lifetime Care on 1300 738 586
or visit [www.icare.nsw.gov.au](http://www.icare.nsw.gov.au)

## Where do I send this form when it is completed?

Lifetime Care

GPO Box 4052, Sydney NSW 2001

**Fax:** 1300 738 583

**Email:** requests.lifetimecare@icare.nsw.gov.au