# **Interim Application Form**

**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**. 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 apply to become an interim participant in the Lifetime Care and Support Scheme (the Scheme), under the Motor Accidents (Lifetime Care and Support) Act 2006. This form should be completed as soon as possible after the accident and must be completed even if a **Severe Injury Advice Form** has been completed.

Lifetime Care pays for reasonable and necessary treatment, rehabilitation and care services for participants in 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 who 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 to 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).
* Part 9 needs to be completed by a suitably qualified medical specialist (e.g. rehabilitation specialist).

## This form is being completed by

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

 CTP Insurer (complete the CTP insurer details on page 10 and attach copy of claim form)

|  |
| --- |
| **Other** |
|  |

|  |
| --- |
| ****Where do I send this form when it is completed?**** Lifetime Care  GPO Box 4052, Sydney NSW 2001  **Fax:** 1300 738 583  **Email:** care-r[equests@icare.nsw.gov.au](mailto:equests@icare.nsw.gov.au) |

## About the information in this form

The information in this form is used by Lifetime Care to determine eligibility for interim participation in the Scheme. If you are not eligible for the Scheme, but have an ongoing CTP claim Lifetime Care will use your information to determine if your treatment and care needs can be met by CTP Care. For more information about CTP Care, please refer to the CTP Insurance section below.

It’s important that the questions are answered fully to avoid any delays in processing this application. Please provide as much information as you can. If you don’t know an answer you can write “not known” in the box.

## 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 attached **Privacy principles information sheet** (pages 18–19) tells you how this information is managed. 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. If Lifetime Care determines you are eligible for CTP Care, Lifetime Care will use the information collected to perform its functions under the *Motor Accident Injuries Act 2017*.

## How to apply

1. Report the accident to the police. Obtain the event number and, if available, the attending officer’s name and police station. Attach the police report where possible. If the vehicle was unregistered, please contact the State Insurance Regulatory Authority (SIRA) CTP Assist for advice on 1300 656 919 or email [ctpassist@sira.nsw.gov.au](mailto:ctpassist@SIRA.nsw.gov.au).
2. A responsible person must complete this form if the injured person is under 18 years. A responsible person may include a parent, a guardian, a carer or a close friend or relative (as defined in the Guardianship Act 1987).
3. The medical certificate section of this form must be completed by a medical specialist and supporting documentation attached. Delays in processing your application may occur if the medical certificate and supporting documents are not complete.
4. Send this form, the medical certificate, and any other relevant documents to Lifetime Care.

## After you send your application

1. We’ll acknowledge receipt of the application within 10 working days. The letter will include a reference number for use in future correspondence. If you haven’t heard from us after 10 days of sending your application, please contact us.
2. We’ll review the application to see if it’s complete and whether additional information is required. You’ll be contacted if this is the case.
3. We’ll advise you of our decision about the application and your eligibility for interim participation in writing.
4. If the application is accepted, you’ll become an interim participant of the Scheme for a two-year period.
5. We’ll then pay hospital, medical, rehabilitation and attendant care expenses where these expenses are reasonable and necessary, and related to the injuries caused by the motor accident.
6. A decision as to whether you are eligible for lifetime participation will be made within two years from the date of the interim decision.
7. If you disagree with our decision about eligibility, contact the Assessment Review team at Lifetime Care on 1300 738 586 for information on the dispute resolution process.
8. If the application is not accepted, but you have an ongoing CTP claim Lifetime Care will use your information to determine if your treatment and care needs can be met by CTP Care.

|  |
| --- |
| CTP Insurance 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 do not meet the Scheme injury criteria may be eligible to have their treatment, and care expenses paid for by the CTP insurer of the vehicle that was most at fault in the accident. CTP Care The CTP Care program (CTP Care) is administered by Lifetime Care in the NSW Compulsory Third Party (CTP) Scheme under the *Motor Accident Injuries Act 2017.* People injured in a motor accident in NSW from 1 December 2017 will have their treatment and care needs met through CTP Care when they have needs five years after the motor accident.  CTP Care may start earlier than five years when agreed with the CTP insurer. If you are not eligible for the Scheme, and you have an ongoing CTP claim, Lifetime Care will use your information to decide if your treatment and care needs can be met by CTP Care.  Further information on how to make a CTP claim or check the status of 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](mailto:ctpassist@sira.nsw.gov.au). |

## ****1. Personal details of the injured person****

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | **Surname** | | **First Name(s)** | | | | |
|  |  | |  | | | | |
| **If known by any other names, please list below** | | | | | **Gender** | | |
|  | | | | | Male  Female  Other | | |
| **Date of birth** | | **Was the injured person under 16 at the time of the accident?** | | | | | |
|  | | Yes  No | | | | | |
| **Home phone** | | **Mobile phone** | | | **Email address** | | |
|  | |  | | |  | | |
| **Address** | | | | | | | |
|  | | | | | | | |
| **Suburb** | | | | **State** | | | **Postcode** |
|  | | | |  | | |  |
| **Postal Address (if different from above)** | | | | | | | |
|  | | | | | | | |
| **Suburb** | | | | **State** | | | **Postcode** |
|  | | | |  | | |  |
| **To ensure we consider your cultural needs for the services and support you may be eligible for:** | | | | | | | |
| **Are you a First Nations person?** | | | | | | | |
| **Yes – Aboriginal**   **Yes – Torres Strait Islander**  **Yes, both Aboriginal & Torres Strait Islander**  **If yes, what is your Nation/Country?**        **No**  **I do not wish to disclose**  **Unknown** | | | | | | | |
| **Do you identify with another culture?** | | | | | | | |
| **Yes If yes, which culture?**  **No**  **I do not wish to disclose**  **Cultural identity unknown** | | | | | | | |
| **Do you require an interpreter?** | | | | | | **Language** | |
| No  Yes – complete interpreter declaration on page 11 | | | | | |  | |

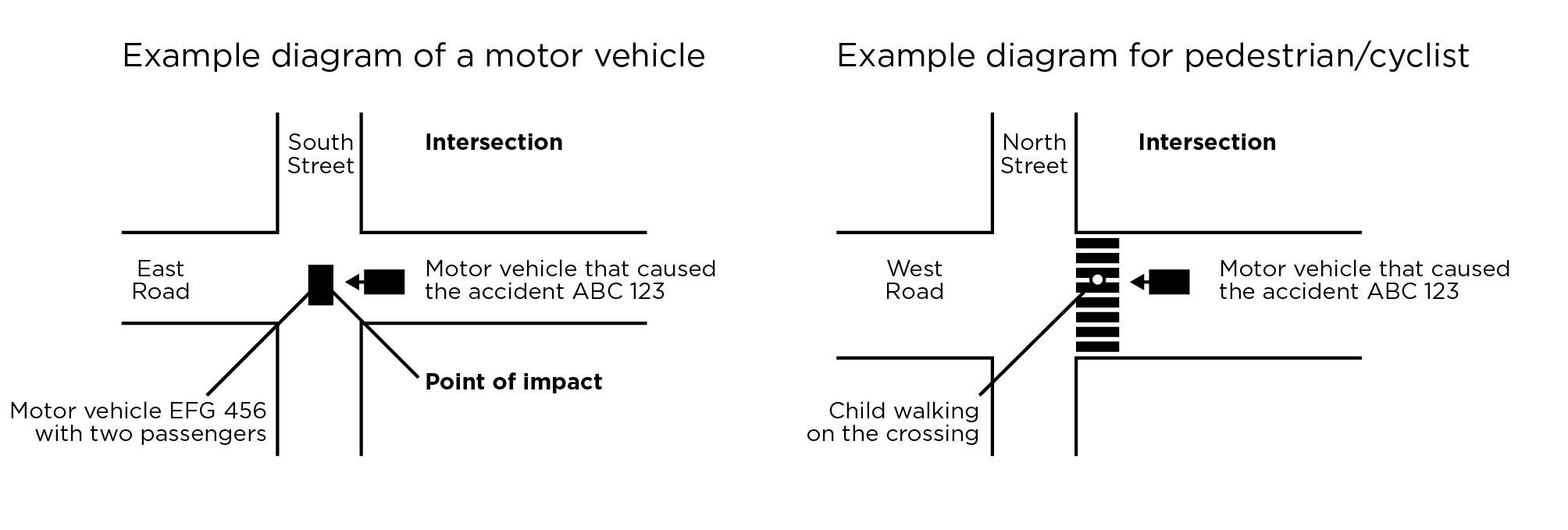
## ****2. Personal details of person responsible** (see p1, “Who can complete this form?”)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | **Surname** | | | **First Name(s)** | | | | |
|  |  | | |  | | | | |
| **Relationship to injured person** | | | **Home phone** | | | **Work phone** | | |
|  | | |  | | |  | | |
| **Mobile phone** | | **Email address** | | | | | | |
|  | |  | | | | | | |
| **Address** | | | | | | | | |
|  | | | | | | | | |
| **Suburb** | | | | | **State** | | | **Postcode** |
|  | | | | |  | | |  |
| **Is an interpreter required?** | | | | | | | **Language** | |
| No  Yes – complete interpreter declaration on page 11 | | | | | | |  | |

## 3. Accident details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of the accident** | **Time of accident** | | **Location of accident** | |
|  |  | |  | |
| **Police station** | | **Event number** | | **Attending officer** |
|  | |  | |  |
| **Injured person’s part in the accident?** | | | | |
| Driver  Motorcycle rider  Pedestrian  Pillion passenger  Passenger  Cyclist  Other | | | | |
| **Did the accident happen in the course of employment?** | | | | |
| Yes  No | | | | |
| **Has a CTP or Workers Compensation claim been submitted?** | | | | |
| CTP  Workers Compensation  No | | | | |
| **Insurers Details** **CTP Insurer’s name** | | **Claim number** | | **Insurer’s contact person** |
|  | |  | |  |
| **Phone** | | **Email** | | |
|  | |  | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Postal Address** | | | | | |
|  | | | | | |
| **Suburb** | | | **State** | | **Postcode** |
|  | | |  | |  |
| **Workers Compensation Insurer’s name** | | **Claim number** | | **Insurer’s contact person** | |
|  | |  | |  | |
| **Phone** | **Email** | | | | |
|  |  | | | | |
| **Postal Address** | | | | | |
|  | | | | | |
| **Suburb** | | | **State** | | **Postcode** |
|  | | |  | |  |
| **Was the accident caused by a motor vehicle?**  **Yes**  **No** | | | | | |
| **Briefly describe the accident including who was considered to have caused the accident and how the accident happened** | | | | | |
|  | | | | | |
| **Draw a diagram of the accident. Include intersections, streets, roads and their names. Show the point of the impact and position of all motor vehicles.** | | | | | |
|  | | | | | |



## 4. Details of motor vehicles involved in the accident **(provide as many details as possible)**

|  |
| --- |
| **4.1 How many motor vehicles were involved in the accident?** |
|  |

**4.2 Provide details of the motor vehicles involved in the accident**

**Vehicle 1**

|  |  |  |  |
| --- | --- | --- | --- |
| **Registration number plate** | **State** | **Make and model (e.g. Toyota Camry)** | **Type (e.g. station wagon)** |
|  |  |  |  |

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

**Is this considered the vehicle that caused the accident?**  **Yes**  **No**

**Vehicle 2**

|  |  |  |  |
| --- | --- | --- | --- |
| **Registration number plate** | **State** | **Make and model (e.g. Toyota Camry)** | **Type (e.g. station wagon)** |
|  |  |  |  |

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

**Is this considered the vehicle that caused the accident?  Yes  No**

**Vehicle 3**

|  |  |  |  |
| --- | --- | --- | --- |
| **Registration number plate** | **State** | **Make and model (e.g. Toyota Camry)** | **Type (e.g. station wagon)** |
|  |  |  |  |

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

**Is this considered the vehicle that caused the accident?  Yes  No**

## ****5. Injury details****

5.1 What are the person’s injuries as a result of the accident?

 Brain injury     Spinal cord injury     Amputation/s     Burns     Blindness

|  |
| --- |
| **5.2 Other injuries** |
|  |

5.3 Did the injured person need an ambulance?  Yes  No

5.4 Did the injured person go to a hospital after the accident?  Yes  No

|  |  |
| --- | --- |
| **Which hospital?** | **Date attended** |
|  |  |

5.5 Was the injured person admitted to a hospital or rehabilitation facility?  Yes  No

|  |  |
| --- | --- |
| **Which hospital?** | **Date admitted or treated** |
|  |  |
| **Which hospital?** | **Date admitted or treated** |
|  |  |
| **Which hospital?** | **Date admitted or treated** |
|  |  |

5.6 Has the injured person been discharged from hospital?  Yes  No

|  |  |
| --- | --- |
| **Which hospital?** | **Date discharged** |
|  |  |

## ****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.**

* Lifetime Care is authorised under Part 8 of the Motor Accidents (Lifetime Care and Support) Act 2006 to obtain information and documents relevant to this application from specified persons in connection with the application.
* If the injured person is under 18 years or is unable to make the declaration, a person responsible must make the declaration. A person responsible within the meaning of section 33A (4) of the Guardianship Act 1987, can be a guardian, a spouse or partner, a carer or a close friend or relative (as defined in the Guardianship Act 1987).
* The processing of the application may be delayed if the declaration is not properly completed.
* The way Lifetime Care collects, uses and discloses personal and health information is governed by NSW privacy laws.

### Consent

I consent to Lifetime Care obtaining and sharing information and documents relevant to this application and to make decisions about my/the injured person’s treatment, rehabilitation and care needs. I understand that the information obtained includes personal and health information.

I authorise Lifetime Care, to contact

* 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).

for the purposes of obtaining and sharing information and documents relevant to the application and my/the injured person’s treatment, rehabilitation and care needs.

## Declaration

I declare that I have read and understood the attached Lifetime Care **Privacy principles** and that the information I provide in connection with this application is true and correct. I make this declaration knowing that it is an offence under Part 5A of the Crimes Act 1900 to make a statement or provide information in support of this application that I know to be false or misleading.

|  |  |
| --- | --- |
| **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. CTP insurer applications

**If a CTP insurer is completing this form, a copy of this application must be sent to the injured person. Please attach a copy of the CTP claim form, any relevant accident investigation reports, police reports and any other documents.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **CTP Injurer’s name** | **CTP claim number** | | | **Insurers contact** | |
|  |  | | |  | |
| **Phone** | | **Fax** | | | |
|  | |  | | | |
| **Postal Address** | | | | | |
|  | | | | | |
| **Suburb** | | | **State** | | **Postcode** |
|  | | |  | |  |
| **Claim status** | | | | | |
|  | | | | | |

A copy of this application has been sent to the injured person or their person responsible?

Yes  No

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

## 8. Interpreter assistance

If you need an interpreter to help you read and/or fill in this form, contact Associated Translators & Linguists Pty Ltd on (02) 9231 3288 between 8.30am to 5.00pm, Monday to Friday. This is a free service. If you do need an interpreter to help you with this form, the declaration below must be completed by the interpreter and the injured person or their person responsible.

### Interpreter declaration

1. I declare that the Lifetime Care and Support **Interim Application Form** has been read to the undersigned injured person or their person responsible by the undersigned interpreter.
2. I understand that Lifetime Care and Associated Translators & Linguists Pty Ltd bear no responsibility for any loss whatsoever arising from the interpreting service provided.
3. I acknowledge that the interpreting service provided by Associated Translators & Linguists Pty Ltd was limited to reading and filling in this **Interim Application Form**.
4. This declaration has been read to the injured person or their person responsible by the undersigned interpreter.

|  |  |
| --- | --- |
| **Name of injured person (or person responsible)** | **Injured person’s signature (or person responsible)** |
|  |  |
| **Interpreter’s name** | **Interpreter’s signature** |
|  |  |

## 9. Medical certificate

|  |  |
| --- | --- |
| **Surname of injured person** | **First name(s) of injured person** |
|  |  |
| **Date of birth** | **Gender** |
|  | **Male**  **Female** |

Was the injury described below caused by the motor accident?

Yes  No

Are the injuries consistent with the circumstances of the motor accident described to you?

Yes  No

Does the injury meet the criteria for eligibility for participation in the Lifetime Care and Support Scheme as outlined in Part 1 of the LTCS Guidelines set out below?

Yes (complete boxed section(s) below)

No

**Please complete all applicable severe injury categories.**

|  |  |
| --- | --- |
| **Surname of injured person** | **First name(s) of injured person** |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Brain injury I certify that the injured person has sustained a brain injury caused by the motor accident. The brain injury meets the criteria below, as outlined in Part 1 of the LTCS Guidelines:  Complete both sections below:   The duration of PTA is greater than 1 week.   |  |  |  | | --- | --- | --- | | Number of days in PTA |  | *Attach PTA scoring sheets* |   If the PTA score is not available or not applicable (for example, if the injured person is a child under 8 years of age, or the injured person has a penetrating brain injury):  There is evidence of a very significant impact to the head causing coma for longer than one hour. Where coma has been documented, attach a copy. If not, describe in the box below how this was determined.  **OR**  There is significant brain imaging abnormality, e.g. penetrating injury. Describe in the box below why the abnormality is significant.   |  | | --- | |  |   Attach a copy of the imaging report/s.  **AND**  The injured person is aged over 8 years, has a score of 5 or less on any of the items on the FIM™ or WeeFIM®, **due to the brain injury**, within the last month and **I agree with this FIM™ assessment.**  **OR**  The injured person is a child aged 3 to 8 years, has a score of 2 less than the age norm on any item on the WeeFIM®, **due to the brain injury**, within the last month and **I agree with this FIM™ assessment.**  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.  Attach FIM™ or WeeFIM® score sheet |  |

|  |  |
| --- | --- |
| **Surname of injured person** | **First name(s) of injured person** |
|  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Spinal cord injury (permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction)  I certify that the injured person has sustained a spinal cord injury caused by the motor accident. The spinal cord injury meets the following criteria, as outlined in Part 1 of the LTCS Guidelines:  The spinal cord injury is an acute traumatic lesion of the neural elements in the spinal canal (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit and/or bladder/bowel dysfunction.   |  |  |  |  | | --- | --- | --- | --- | | Neurological (SCI) level: |  | ASIA impairment scale: |  |   Attach ASIA score sheet |  |

|  |  |
| --- | --- |
| Burns I certify that the injured person has sustained full thickness burns caused by the motor accident.  The injury meets the following criteria, as outlined in Part 1 of the LTCS Guidelines:    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 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 a child aged 3 to 8 years, has a score 2 less than the age norm on any item on the WeeFIM®, **due to the burns**, within the last month and **I agree with this FIM™ assessment**.  **OR**    The injured person is aged over 8 years, has a score of 5 or less on any of the items on the FIM™ or WeeFIM®, **due to the burns,** within the last month and **I agree with this FIM™ assessment**.  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.  Attach FIM™ or WeeFIM® score sheet |  |

|  |  |
| --- | --- |
| **Surname of injured person** | **First name(s) of injured person** |
|  |  |

|  |  |
| --- | --- |
| Amputation/s Equivalent impairment means that the person’s limb function is equivalent to an amputation described below.  I certify that the injured person has had one or more amputation/s (or the equivalent impairment) caused by the motor accident. The injury meets the following criteria, described below, as outlined in Part 1 of the LTCS Guidelines: 1. Multiple amputations Multiple amputations of the upper and/or lower extremities, meaning that there is more than one of the following types of amputation at or above, proximal to, the level of: | |
| * a short transtibial or standard transtibial amputation, as defined by the loss of 50% or more of the length of the tibia. This includes all other amputations of the lower extremity (such as knee disarticulation or transfemoral amputation) above this level | Right  Left |
| * a thumb and index finger of the same hand, at or above the first metacarpophalangeal joint. This includes all other amputations of the upper extremity (such as below-elbow or above-elbow amputation) above this level | Right  Left |
| * there are multiple amputations, each of which is an equivalent impairment to an amputation described above (provide details below) | Right  Left |
| * there is at least one amputation and at least one equivalent impairment to an amputation described above (provide details below) | Right  Left |
| Comments   |  | | --- | |  | | |

|  |  |
| --- | --- |
| **Surname of injured person** | **First name(s) of injured person** |
|  |  |

|  |
| --- |
| 2. Unilateral amputations The amputation (or equivalent impairment) is one of the following: |

|  |  |
| --- | --- |
| * forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation | Right  Left |
| * hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy | Right  Left |
| * hip disarticulation (complete amputation of the femur) | Right  Left |
| * short transfemoral amputation as defined by the loss of 65% or more of the length of the femur | Right  Left |
| * brachial plexus avulsion or rupture resulting in an equivalent impairment to an upper limb amputation. (provide details below) | Right  Left |
| * an equivalent impairment to any of the injuries described above (provide details below) | Right  Left |
| * Severe orthopaedic and/or neuromuscular injury of either an upper or lower limb producing an equivalent impairment to the injuries described above (provide details below) | Right  Left |
| Comments   |  | | --- | |  | | |

|  |  |
| --- | --- |
| **Surname of injured person** | **First name(s) of injured person** |
|  |  |

|  |
| --- |
| Permanent blindnessI certify that the injured person has sustained permanent blindness caused by the motor accident. The loss of sight meets one of the following criteria, as outlined in Part 1 of the LTCS Guidelines: a) visual acuity on the Snellen Scale or equivalent after correction by suitable lenses is less than 6/60 in both eyes; or  b) field of vision is constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity (equivalent to 1/100 white test object); or  c) a combination of visual defects resulting in the same degree of visual loss as that occurring in (a) or (b) above. |

|  |
| --- |
| **Additional comments** |
|  |

|  |  |  |
| --- | --- | --- |
| I declare that I have examined |  | in the last three months and the information |
| above is consistent with my examination | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medical specialist\*** | | **Qualification** | |
|  | |  | |
| **Signature** | **Provider number** | | **Date** |
|  |  | |  |
| **Address** | | | **Phone** |
|  | | |  |

\**If the injured person is a child under 3 years and has sustained a brain injury this declaration can only be signed by a paediatric rehabilitation physician*

## Checklist

Before sending this Interim Application form to Lifetime Care please ensure that you have completed the following steps

The accident has been reported to the police

The Lifetime Care **Privacy principles** have been read and understood and the declaration and consent to collect personal information on page 8 has been signed

Medical Certificate and relevant FIM™/WeeFIM®, PTA or ASIA worksheets completed and attached (or

to be sent by treating team)

A copy of the form and any accompanying information have been made for your own records

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

## Privacy principles

### How we collect, store, use and disclose your personal and health information

Lifetime Care respects your privacy and treats the management of your personal and health information very seriously. Our privacy obligations are contained in the Privacy and Personal Information Protection Act 1998 and the Health Records and Information Privacy Act 2002. We follow these legal obligations when collecting, storing, using and disclosing your personal and health information.

The following principles apply to your personal and health information in any form, including electronic or paper records, audio records or x-rays.

### 1. Why we collect information about you

We only collect personal and health information where it is required to perform our functions. We collect your information to determine whether you are eligible to become a participant in the Lifetime Care and Support Scheme (the Scheme); to make decisions about the supports required to meet your treatment and care needs; and to manage your participation in the Scheme.

If you are not eligible for the Scheme, we may also use your information to determine if your treatment and care needs can be met by CTP Care; to make decisions about the supports required to meet your treatment and care needs; and to manage your benefits within the NSW CTP Scheme.

### 2. What kind of information we may collect

We only collect personal and health information that is relevant to your participation in the Scheme or any other treatment and care needs you may be eligible for. This may include, but is not limited to, information about your accident and the injuries you sustained, information about your health including your medical and other treatment and care needs, and information about your current community supports and living arrangements.

### 3. How we use and disclose your information

We will only use and disclose your personal and health information for the purpose for which it was collected or a directly related purpose. We might also disclose your personal or health information for research or the compilation of statistics where it is reasonably necessary and in the public interest. We may disclose information for the purposes of program evaluation and research, including but not limited to, road safety initiatives and service development activities such as vocational programs. We will ensure any the information is de-identified and provided in accordance with Human Research Ethics Committee requirements.

If there’s a dispute about your eligibility to participate in the Scheme, the nature or extent of your injuries, the matter will be referred to an Assessment Panel of independent, external dispute assessors. If there is a dispute about your treatment and care needs, the matter will be referred to one external dispute assessor. If a dispute about eligibility or treatment and care needs is not resolved, the matter may later be referred to a Review Panel.

The assessors will be provided with the same personal and health information that we hold about you. They may also ask for additional information to help them make their assessment.

In the case of a dispute about the nature of the motor accident, we may need to share information with the State Insurance Regulatory Authority (SIRA) and legal advisers.

### 4. Who we might obtain your personal and health information from, or give it to

Entities that Lifetime Care may need to provide documents and/or information to and obtain documents and/or information from include:

* your 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).

### 5. Transferring your information outside New South Wales

Sometimes we may need to transfer your information to other States and Territories, as well as to the Commonwealth. This may be for treatment and care purposes as described above, or as part of the Commonwealth-State reporting obligations. If you live in a different state or overseas we will need to do this most of the time. If we need to transfer your personal or health information outside of NSW we will ensure that we have a lawful authority or your consent to do so.

### 6. Keeping your information relevant and up to date

We take reasonable steps to ensure that your personal and health information is relevant, up to date and complete. We may ask you to verify information we hold about you and to ensure it is accurate. We will ask you to renew your consent to us collecting, using, storing and disclosing your personal and health information every two or three years.

### 7. We keep your information secure

We protect your information from unauthorised access, use, misuse, modification, disclosure and loss. Your information is stored securely, not kept any longer than necessary and disposed of in accordance with our record keeping obligations.

### 8. You can ask to correct your information

If you ask us, we will give you access to your personal and health information, unless denying access is authorised by another law. If required, we will allow you to update, correct or amend your personal or health information.

### 9. If you act for someone who has impaired decision-making capacity or a disability

If you act for someone who is a participant in the Scheme who has impaired decision-making capacity or a disability that means they are unable to give consent to the collection, storage, use and disclosure of their personal and health information you can do so on their behalf if you are 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).

### 10. If there is a dispute about how we are managing your personal or health information

If you believe we are not managing your personal or health information in accordance with these principles, then you have rights to ask us to review our conduct.

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| For more information If you have any questions about privacy, confidentiality or access to your information, you can phone, fax or email us.  Details are below.  Phone our switchboard: 1300 738 586 (from 9:00am to 5:00pm, Monday to Friday)  Send a fax on: 1300 738 583  Email us at: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au)  For further information about how icare, including Lifetime Care, meets its privacy obligations please visit the privacy pages on our website at [www.icare.nsw.gov.au](http://www.icare.nsw.gov.au). |