IMPORTANT

Australian Government
Department of Veterans' Affairs

Vietnam Veterans' Sons and Daughters Support Program (VVSDSP)

Prior Approval Form

Use this form for

Application for Prior Approval for financial assistance following an assessment and quote for Home Modification, Aids and Appliances, expensive medical/dental treatment or physical rehabilitation assistance for VVSDSP registered clients. Assistance will not be provided for services rendered for any condition **not** covered by VVSDSP.

Information

You are advised to refer to the VVSDSP Information Booklet before seeking prior approval for assistance for Home Modifcation, Aids and Appliances, expensive medical/dental treatment or physical rehabilitation assistance. For further information, please read the DVA Factsheet SDP01 available from your State Office, Veteran's Access Network (VAN), or VVCS - Veterans and Veterans Families Counselling Service centre or visit our website www.dva.gov.au

Privacy

The information provided on this form, which is collected under the Veterans' Entitlements Act 1986, will be used to assess your eligibiity for benefits under the VVSDSP. Please note that, as required under the Financial Management and Accountability Act 1997, the Department of Veterans' Affairs may disclose some of the information provided on this form to the Department of Fianance and Deregulation to facilitate payment of your claim. The Department of Veterans' Affairs may also disclose some of the information provided on this form to an authorised health service provider to verify your claim for payment.

Filling in your application

This form can be completed by you, as the eligible VVSDSP registered client, or *(if applicable)* a parent (of a minor child), a guardian or a person with Power of Attorney. Please **complete** and **sign** all relevant questions in the **CLAIMANT** sections. Your health provider must complete the **SERVICE PROVIDER** section and attach **a quote and assessment report**.

Complete this form carefully as an incorrect and/or incomplete form may be returned to you for completion.

Claim

For payment once prior approval has been granted please complete and send the Claim and Reimbursement form (**D9008**) with attached tax invoice.

Contact details

For enquiries relating to this prior approval application please call **1800 550 504**
Please send your completed form to:

The Program Manager
Vietnam Veterans' Sons and Daughters Support Program
Department of Veterans' Affairs
Reply Paid 9998
Brisbane, QLD 4001

Claimant's details

1. **The registered VVSDSP clients name**

2. **Given name(s)**

3. **ID card number** *(if known)*

4. **Home address**

   POSTCODE

5. **Postal address** *(if different from home address)*

   POSTCODE

6. **Contact phone(s)**

   [ ]

   Mobile

7. **E-mail address**

8. **Are you applying for prior approval as the:**

   ☐ Client ☐ Parent (of a minor child)
   ☐ Guardian ☐ Person with a Power of Attorney

9. **Please give details if you are the parent (of a minor child), guardian or a person with a Power of Attorney** *(if applicable)*

   Surname

   Given name(s)

10. **If applying as the guardian or the person with a Power of Attorney, was a certified copy of the guardianship or Power of Attorney sent with either the original registration form or subsequently?** *(if applicable)*

    No ☐ ▶
    Yes ☐

    Please attach a certified copy of the guardiandhip order or Power of Attorney with this claim form.

11. **As the guardian or the person with a Power of Attorney is your mailing address the same as the registered VVSDSP client?** *(if applicable)*

    No ☐ ▶ What is your address?
    Yes ☐

    POSTCODE

    Phone number

    [ ]

    Mobile number

Claimant's Declaration and Consent Authorisation

I am seeking Prior Approval for financial assistance following an assessment and quote for home modifications, aids and appliances, expensive medical/dental treatment or physical rehabilitation assistance (please circle which is applicable).

I declare that the service(s) relate to the treatment of (please tick appropriate box(es)):

- ☐ acute myeloid leukaemia
- ☐ adrenal gland cancer
- ☐ spina bifida manifesta
- ☐ cleft lip
- ☐ cleft palate

The service(s) are not for the purpose of life insurance, superannuation or provident account schemes, admission to a friendly society, health screening, mass immunisation or a health examination requested by an employer.

The service(s) are not covered by a compensation payment.

To the best of my knowledge and belief all the information in this prior approval form is true and correct.

I acknowledge that, under VVSDSP, I will be entitled to financial assistance for my registered medical condition only. I undertake not to make any claims under the program for any other medical condition.

I consent and authorise the Department of Veterans' Affairs to obtain medical, clinical or other information from service providers and other relevant persons or bodies and/or to clarify details of the requested items for prior approval.

I declare that the details I have provided in this form are, to the best of my knowledge, correct. I understand that giving false or misleading information is a serious offence.

Signature of applicant or (if applicable) parent (of a minor child)*/guardian*/Power of Attorney*

Date

/ /

Printed name

* *By signing as the parent (of a minor child), guardian or person with the Power of Attorney you are accepting, on behalf of the applicant, that the information provided on this form is, to the best of your knowledge, correct.*

Service Provider

12. Please specify the item(s) or service to be provided for aids & appliances or home modification or medical/dental or physical rehabilitation treatment plan.

Be specific (e.g. sizes of aids and equipment or treatment plan) including start and end dates etc.

13. Please explain how the specified items or treatment plan meet the VVSDSP client's registered medical condition

If insufficient space, please attach a separate sheet

14. Quote amount

$

15. Quote and/or copy of treatment plan (including start and end dates) attached?

No ☐ ▶ Please give reason

Yes ☐

16. Start date

/ /

17. End date

/ /

Note: If there is more than one service provider then please complete a new form and attach to this form.

18. Provider type

19. Name

20. Address

POSTCODE

21. Telephone number

[ ]

22. Provider number

23. Provider stamp

Service Provider declaration

I declare that:

- the purpose of the service was for the determination of the patient's medical need for the item/equipment/home modification or treatment plan prescribed;
- the item/equipment/home modification or treatment plan prescribed is necessary for the patient's medical condition indicated on this form.

I declare that to the best of my knowledge and belief, all information provided is true and correct.

Service provider signature

Date

/ /

Claimant - completed form

Please send your completed form together with a quote and an assessment report to:

The Program Manager
Vietnam Veterans Sons and Daughters Support Program
Reply Paid 9998
Brisbane, QLD 4001

Save Print Clear

VVSDSP Office Use Only

Date received	/ /
Authorisation date	/ /
Authorised by (print name)	
Signature	