**Delegate Approval Request Form**

Submit this form for the following equipment or home modification requests:

* Clients 65 years and over and are clients of Commonwealth Continuity of Support Programme (CoS) (Cat 2 items)
* Clients 65 years and over and are active Equipment Program clients or require customised mobility (Cat 2 items)
* Clients requesting funding through “Adults with chronic Conditions (ACC) (“Y2” on in scope list)

Please only use one form per item (or equipment packages – e.g. mobile shower chair with custom seating). All sections on the form must be completed before the request will be considered.

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| Client Name: | | DOB: | **Internal Use only – met criteria?** |
| Assessor Name: | **Discipline:** | Date: |
| **Request Details** | | |
| 1. **What is the item being requested?**   Note: Only the most cost-effective solution for the client’s circumstances will be approved. Equipment Program staff will assist in matching to the most suitable option, and where available, readily available and refurbished options will be offered in the first instance.  Assessors will be advised of the outcome of this request. Some requests may be subject to demand management. | | |
| Is this a replacement item or a new need?  Replacement  New need | | |
| Is this item on the Equipment Program *equipment* or *home modification* “I*n-scope List”?*  No - Do not proceed with request as client is not eligible.  If there are exceptional circumstances, discuss these with an Equipment Program delegate.  Yes – continue to question 4 | | |  |
| 4. Client’s Relevant Diagnosis: | | |  |
| **5. Explain the clinical need and any relevant supporting information for the requested item, and how it meets the “*Key Approval Criteria*” (for equipment or home modifications).** *Consider including social situation, current issues and recommendations to support the request.*    Note, if the client does not meet the key approval criteria, do not proceed with the request as client is not eligible. | | |  |
| 6. Does the item requested have a “Criteria Screening Tool”? Refer to in scope list.  No - continue to question 7  Yes - attach the completed “*Criteria Screening Tool”* and continue to question 8  Note: Equipment Program Delegates make the final decision regarding eligibility, taking into account all information provided. Do not indicate to a client they are eligible, irrelevant of the outcome of the screening tool. | | |  |

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| 1. **Does the request meet the *“Specific Eligibility Criteria”?*** *Refer to in scope list.*   Not Applicable (item does not have specific eligibility criteria) - continue to question 8  No - Do not proceed with request as client is not eligible  Yes - **How does the client meet the relevant Specific Eligibility Criteria for this item?** *Provide additional information to support case (where not already noted above.)* | | | | |  |
| **8. Referring to the *“Risk Rating & Priority Scoring Form”*, explain the risks to the client and/or carers without the equipment or home modification.** *Include justification for likelihood and consequence ratings from the tool.* | | | | |  |
| **Final Check Before Submitting to** [DHSEquipmentProgram@sa.gov.au](mailto:DHSEquiomentProgram@sa.gov.au)  **NB: Images must be emailed** | | | | |  |
| Have you completed a home visit to assess for this equipment/ home modification? Y  N  Attach the following documents (available on website):  *Equipment Program Equipment Request Form* **OR**  *Equipment Program Home Modifications Request and Agreement Form*  **AND**  *Assessment Form* (required for certain items, refer to in-scope list)  Home visit or assessment report (optional)  *Criteria Screening Tool* (required for certain items, refer to in-scope list)  *Risk Rating & Priority Scoring Form* (required)  *Specification Form* (required for certain items, refer to in-scope list)  Diagrams and images for home modification requests (required) | | | | |  |
| **Internal Use Only** | | | | | |
| CSO Check Completed | | | | | |
| Name | | Signed | | Date | |
| Delegate Check: | | | | | |
| Approved? Y  N | Approved Priority Score: | | Resources Available? Y  N | | |
| Name | Signed | | Date | | |
| Notes: | | | | | |