# Interim Application Form

**This form contains information about the Lifetime Care and Support Scheme (Lifetime Care). Lifetime Care is a service line in Insurance & Care NSW (icare). If you have any questions after reading this form, please call us on 1300 738 586 or visit www.icare.nsw.gov.au.**

To help avoid any delay in making our decision, 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 |

## Lifetime Care

This form is to apply to become an interim participant in Lifetime Care 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.

We pay for reasonable and necessary treatment, rehabilitation and care services for participants in Lifetime Care.

### Eligibility

You may be eligible for Lifetime Care if you are either:

|  |  |  |
| --- | --- | --- |
| A person aged 16 years or over who has been severely injured in a motor accident in NSW from 1 October 2007 | OR | A child under 16 years who have been severely injured in a motor accident in NSW from 1 October 2006 |

AND

have sustained one of the following injuries in the 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 (with support where required) or a person with parental responsibility if the injured person is a child. 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’s representative, including a legal guardian, a person acting under an enduring power of attorney or a person responsible within the meaning of section 33A (4) of the *Guardianship Act 1987*, being a guardian who is appointed to give consent to carry out medical or dental treatment on the person, a spouse or partner, a carer or a close friend or relative (as defined in the *Guardianship Act 1987*) or a person acting under some other lawful authority
* A person with parental responsibility or a person’s representative is referred to as a person responsible throughout this form
* 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?")

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

Other:

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

## About the information in this form

We use the information in this form to decide your eligibility for interim participation in Lifetime Care. If you are not eligible for Lifetime Care but have an ongoing CTP claim, we will use your information to determine if CTP Care can meet your treatment and care needs. For more information about CTP Care, please refer to the CTP Insurance section below.

## Your privacy

Your personal and health information will be managed according to 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. We collect your personal and health information so Lifetime Care can administer the Lifetime Care and Support Scheme and perform 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 our 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.

2. A person responsible must complete this form if the injured person is under 18 years or the injured person has impaired decision-making capacity or a disability.

3. A medical specialist must complete the medical certificate section of this form and attach any supporting documentation. 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 in writing. The letter will include a reference number for use in future correspondence. If you haven’t heard from us after 10 working days of sending us 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 Lifetime Care for two years.

5. We’ll then pay hospital, medical, rehabilitation and attendant care expenses if they are reasonable and necessary, and related to the injuries caused by the motor accident.

6. You will need to make a new application for lifetime participation. 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 your eligibility for participation in Lifetime Care, you can lodge a dispute. You can find more information about eligibility disputes on our website [www.icare.nsw.gov.au](http://www.icare.nsw.gov.au) or contact us on 1300 738 586.

If you are not eligible for Lifetime Care and have an ongoing CTP claim, Lifetime Care may 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 Lifetime Care 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 Scheme (CTP Care) is administered by Lifetime Care through the NSW Compulsory Third Party (CTP) Scheme which was established 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 Lifetime Care, and you have an ongoing CTP claim, the Lifetime Care and Support Authority 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. |

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title | Last Name | | First Name(s) | | | | |
|  |  | |  | | | | |
| If known by any other names, please list below | | | | Gender | | | |
|  | | | | Male  Female  Other | | | |
| Date of birth | | Was the person under 16 at the time of the accident? | | | | | |
| Click or tap to enter a date. | | Yes  No | | | | | |
| Home phone | | Mobile | | | 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 require an interpreter? | | | | | | | Language |
| No  Yes – complete interpreter declaration on page 10 if assisting with form completion | | | | | | |  |

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title | Last Name | | | First Name(s) | | |
|  |  | | |  | | |
| Relationship to injured person | | | Home phone | | Work phone | |
|  | | |  | |  | |
| Mobile phone | | Email address | | | | |
|  | |  | | | | |
| Address | | | | | | |
|  | | | | | | |
| Suburb | | | | State | | Postcode |
|  | | | |  | |  |

## 3. Accident details

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date of the accident | Time of accident | | Location of accident | |
| Click or tap to enter a date. |  | |  | |
| 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 | | | | |

### ****Insurer’s details (if applicable)****

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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. |
|  |

## 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 |
|  | Click or tap to enter a date. |

5.5 Was the injured person admitted to a hospital or rehabilitation facility?

Yes  No

|  |  |
| --- | --- |
| Which hospital? | Date admitted or treated |
|  | Click or tap to enter a date. |
| Which hospital? | Date admitted or treated |
|  | Click or tap to enter a date. |
| Which hospital? | Date admitted or treated |
|  | Click or tap to enter a date. |

5.6 Has the injured person been discharged from hospital?

Yes  No

|  |  |
| --- | --- |
| Which hospital? | Date discharged |
|  | Click or tap to enter a date. |

## 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.**

* The Lifetime Care and Support Authority 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 with parental responsibility or the person’s representative, including a legal guardian, a person acting under an enduring power of attorney or 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 who is appointed to give consent to carry out medical or dental treatment on a person, a spouse or partner, a carer or a close friend or relative (as defined in the *Guardianship Act 1987*) or a person acting under some other lawful authority.
* The processing of the application may be delayed if the declaration is not properly completed.
* The way the Lifetime Care and Support Authority collects, uses and discloses personal and health information is governed by NSW privacy laws.

### ****Consent****

I consent to the Lifetime Care and Support Authority obtaining and sharing information and documents relevant to this application and to assess and make decisions about services to meet my/the injured person’s treatment, rehabilitation and care needs. This includes the sharing of relevant information and documents relating to services funded by the Lifetime Care and Support Authority. I understand that the information obtained and shared includes personal and health information.

I authorise the Lifetime Care and Support Authority, to contact

* my/the injured person’s family or guardian
* the State Insurance Regulatory Authority (SIRA)
* any New South Wales government agency
* a hospital, including a private hospital
* police department, to obtain information about the accident, including, but not limited to, the police report
* an ambulance 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)
* 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, including the National Disability Insurance Agency
* if you live in or travel to a State or Territory outside NSW or overseas, any private or government entity necessary to deliver treatment and care services to you or otherwise manage your participation in the Scheme.

### ****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 |
|  | Click or tap to enter a 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 |
|  | | Click or tap to enter a 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 Insurer’s name | CTP claim number | | Insurer’s contact person | |
|  |  | |  | |
| Phone | Fax | | | |
|  |  | | | |
| Postal Address | | | | |
|  | | | | |
| Suburb | | State | | Postcode |
|  | |  | |  |
| Claim status | | | | |
|  | | | | |

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

Yes  No

|  |  |
| --- | --- |
| Do they agree to this application? | Date claim received? |
| Yes  No | Click or tap to enter a date. |

## 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 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’s representative.

Interpreter declaration

1. I declare that the Lifetime Care **Interim Application Form** has been read to the undersigned injured person or their person’s representative 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 the person responsible by the undersigned interpreter.

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

## 9. Medical certificate

|  |  |
| --- | --- |
| Last name of injured person | First name(s) of injured person |
|  |  |
| Date of birth | Gender |
| Click or tap to enter a date. | 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 (LTCS) 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.**

|  |  |
| --- | --- |
| Last name 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 following criteria, 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.   |  | | --- | |  | | 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.  **OR**  Criteria not met. Please describe:   |  | | --- | |  |   *Attach FIM™ or WeeFIM® score sheet* |  |

|  |  |
| --- | --- |
| Last name 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*** |  |

|  |  |
| --- | --- |
| Last name 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   |  | | --- | |  |  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   |  | | --- | |  | | | | | | |  |

|  |  |
| --- | --- |
| Last name of injured person | First name(s) of injured person |
|  |  |

|  |
| --- |
| Permanent blindness I 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 |
|  |  | | Click or tap to enter a 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

|  |  |
| --- | --- |
|  | icare GPO Box 4052, Sydney, NSW 2001 **General Phone Enquiries: 1300 738 586** Fax: 1300 738 583 Email: [care-requests@icare.nsw.gov.au](mailto:care-requests@icare.nsw.gov.au) 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 within the NSW CTP Scheme by CTP Care. This will include CTP Care making decisions about the supports required to meet your injury related 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 and future community supports and living arrangements. These include treatment, care and supports that may be funded by bodies other than Lifetime Care, such as the National Disability Insurance Agency or a Workers Compensation Insurer.

### 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. This includes disclosing information relevant to your treatment, rehabilitation and care needs to health providers engaged to provide you with services. 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 information is de-identified and provided in accordance with any relevant Human Research Ethics Committee requirements.

If there’s a dispute about your eligibility to participate in the Scheme, 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 independent, 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 external dispute 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 hospital, including a private hospital
* the police department, to obtain information about the accident, including, but not limited to, the police report
* an ambulance 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)
* 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, including the National Disability Insurance Agency
* 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.

### 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 do so lawfully.

### 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 Lifetime Care, or who may become a participant in Lifetime Care, 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’s representative, including a legal guardian, a person acting under an enduring power of attorney or a person responsible within the meaning of section 33A (4) of the Guardianship Act 1987,who is appointed to give consent to carry out medical or dental treatment on the person, being a guardian, a spouse or partner, a carer or a close friend or relative (as defined in the Guardianship Act 1987) or a person acting under some other lawful authority.

### 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.  **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)  Alternatively, you can also contact Lifetime Care at [feedback.lifetimecare@icare.nsw.gov.au](mailto:feedback.lifetimecare@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)**.** |