Australian Government
Department of Health

Form A*

Application for Australian Government financial assistance for individuals with Inborn Errors of Metabolism - *DHPR, Hyperphenylalaninemia and PKU Conditions Only

Details of the person making the grant application (responsible person for purchasing the necessary dietary foods)

New Application ☐ Re-application ☐

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

Given Name:

Surname:

Address Line 1:

Address Line 2:

Suburb or City:

State/Territory: Post Code:

Phone Number:

Mobile Number:

Email Address:

Postal Address: (if different to residential address):

Line 1:

Line 2:

Suburb or City:

State/Territory: Post Code:

Relationship to person with IEM:

☐ Self (must be 18+) Parent: ☐ Mother ☐ Father

☐ Legal guardian ☐ Carer (family/org)

Banking Institution:

Account Name: e.g. John Citizen

BSB (6 digits):

Account number:

PRIVACY AND YOUR PERSONAL INFORMATION

The Australian Department of Health (**the Department**) collects personal information under the Inborn Errors of Metabolism Program (the Program) for the purposes of determining the initial or continuous eligibility of an applicant (a patient with an IEM condition or the parent/legal guardian/carer of the patient) to receive financial assistance under the Program, and to administer the payments of financial assistance.

In order to administer the Program, the Department collects personal information about the applicant, the patient (in circumstances where the applicant is not the patient) and the metabolic specialist of the patient. Where the applicant is the patient, the personal information collected about the applicant will include information about the applicant's health. This information may be collected from the patient, the parent/legal guardian/carer of the patient and the metabolic specialist of the patient.

The Department can be contacted by telephone on (02) 6289 1555 or freecall 1800 020 103 or by using the online enquiries form at www.health.gov.au.

If you (the patient with the IEM condition, the parent/legal guardian/carer of the patient, or the metabolic specialist of the patient as applicable) do not provide the information referred to above, the Department may not have the necessary information to:

- make a decision on the applicant's eligibility for financial assistance under the Program; and/or
- administer the payments of financial assistance under the Program.

The Department discloses patients' personal information such as name, date of birth, address and Medicare card number to the Department of Human Services to confirm their Australian residency status and Medicare enrolment.

The Department has an Australian Privacy Principles (APP) privacy policy which you can read at http://www.health.gov.au/resources/publication/privacy-policy. A copy of the APP privacy policy can be obtained by contacting the Department using the contact details set out above. The APP privacy policy contains information about:

- how you may access the personal information the Department holds about you and how you can seek correction of it; and
- how you may complain about a breach of the Australian Privacy Principles and how the Department will deal with such a complaint.

The Department is unlikely to disclose your personal information to overseas recipients.

CONSENT TO COLLECTION OF SENSITIVE INFORMATION

I consent to the Department of Health collecting my health information (or the health information of the person with the IEM condition where applicable) for the purpose of determining my eligibility to receive financial assistance under the IEM Program and administer the payments for financial assistance.

Applicant/Patient Declaration

I confirm that I am a person with an IEM condition as stated in this form, or a parent / guardian / carer of such an individual, and hereby apply for Commonwealth financial assistance for individuals with these conditions.

I undertake to inform the Department of Health:

- if the patient ceases the prescribed diet;
- if the patient relocates overseas;
- of any changes to the details provided on this form, including contact and bank account details; and
- of any changes to the patient's custody / care arrangements (if applicable).

I understand that:

- the application is valid for 12 months from the date of approval. The patient with these conditions must reapply every 12 months through a metabolic specialist recognised by the Department of Health to continue with the Program.
- if the patient ceases the prescribed diet, all financial assistance to the patient will cease. To reapply, patients must consult their metabolic specialist for assessment of their condition and provide supporting documentation advising the patient continues to have special dietary needs.
- changes in custody / care arrangements require redirection of financial assistance to the patient's primary Parent / Guardian / Carer. A primary Parent / Guardian / Carer is a person / organisation who has majority custody / care of the patient.
- failure to notify the Department of Health of changes in circumstances may result in the Department suspending the financial assistance and pursuing repayment of any overpaid funds from the applicant.

I declare that I have read the above and that all information provided in this application is current and correct.

Name:

(Please print)

Signature: _____

(Person signing must be 18 years or older)

Date: _____

IEM program, Portfolio Strategies Division
MDP 1060, GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 8980 Email: iemprogramofficer@health.gov.au

Form A*

*DHPR, Hyperphenylalaninemia and PKU Conditions Only

METABOLIC SPECIALIST'S CERTIFICATION
(***Doctor must be registered by the Department of Health as a metabolic specialist under the IEM Program***):

Details of the person with IEM condition requiring review:

First Name: _____

Surname: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

☐ Intersex

☐ Indeterminate or unspecific

Residency particulars:

☐ Australian Citizen ☐ Permanent Australian Resident

Medicare number: _ _ _ _ _ _ _ _ _ _

Diagnosis: (please tick patient's IEM condition)

☐ Dihydropteridine reductase (DHPR) deficiency

☐ Hyperphenylalaninemia

☐ Phenylketonuria (PKU)

Medically prescribed diet required:
(please tick as appropriate)

☐ Ongoing ☐ Preconception ☐ Pregnancy

Period of dietary prescription:

_____

METABOLIC SPECIALIST'S DECLARATION

I certify that the aforementioned person has a diagnosed IEM and has a requirement for a special diet to manage their condition. I agree to the collection of my information for the purpose of determining the patient's eligibility.

SELECT ONE:

☐ I certify that the patient is compliant with diet, appointment and monitoring requirements.

OR

☐ I certify that concern about this patient's compliance has been raised with them/their family. An action plan to address this has been put in place.

OR

☐ I certify that I have no evidence that patient is currently on the prescribed diet.

Name: _____
(Please print)

Phone Number: _____

Email Address: _____

Signature: _____

Date: _____

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