- **Free Hearing aids & services for Pensioners & Veterans**

- **DOCTOR'S APPOINTMENT**
- **take this application form[SEE BELOW] with your details and ask Doctor to sign application.**
- **PHONE 6360 1884 to make an appointment at Dubbo or Orange clinics. Dr may fax completed form to 6361 4480, you may post or take to Suite 1/256 Anson Street, Orange. If easier please bring application to your appointment.**
- **YOUR OHS VOUCHER will be processed in our clinic ready for your appointment on receipt of your completed application**

Australian Government Hearing Services Program - Application Form

ELIGIBILITY TYPE*

Tick the relevant box that relates to your eligibility*:

- ☐ (a) Centrelink Pensioner Concession Card
- ☐ (b) Centrelink Sickness Allowance
- ☐ (c) DVA Pensioner Concession Card
- ☐ (d) DVA Gold Health Repatriation Card
- ☐ (e) DVA White Health Repatriation Card (for hearing loss)
- ☐ (f) Dependent of someone with one of the above concessions
- ☐ (g) Current Serving Member of the Australian Defence Force

ELIGIBILITY & APPLICANT DETAILS*

The following details are needed so we can confirm your eligibility:

Eligibility Number* *e.g. your CRN or DVA number*

Title | Given Name* | Middle Name

Family Name *

Date of Birth (dd/mm/yyyy)* | Gender*

DEPENDENT CONCESSION CARD HOLDER DETAILS

If you ticked option 'f' in the eligibility type above, please provide the following concession card holder details:

Eligibility Type | Eligibility Number

Given Name | Family Name

Date of Birth (dd/mm/yyyy)

PRIVACY AND YOUR PERSONAL INFORMATION

Your personal information is protected by law, including the *Privacy Act 1988*, and is being collected by the Australian Government Department of Health (the Department) for the purposes of determining eligibility for and administering the Hearing Services Program.

If you do not provide this information then the Department will not be able to provide you with hearing services under the program.

You can get more information about the way in which the Department will manage your personal information, including our privacy policy at www.health.gov.au/hear.

By signing this form you are consenting to and authorising the Department to collect, store and disclose your information, including personal information.

Signature* | Date*

Residential Address*

Suburb* | State* | Postcode*

Contact Phone 1 | Contact Phone 2

Optional Information (used for planning purposes)

Are you a resident of an aged care facility?	☐ Yes
Are you of Aboriginal origin?	☐ Yes
Are you of Torres Strait Islander origin?	☐ Yes
Do you speak a language other than English at home? If yes, please provide languages spoken.	☐ Yes

DETAILS OF MEDICAL PRACTITIONER*

Medical Practitioner (MP) Name *

Contact Number* ( )

Are there any contraindications for the fitting of a hearing device*

YES ☐ (May still be eligible for other services)

NO ☐

Signature* | Provider Number* | Date*

APPLICANT CORRESPONDENCE PREFERENCES

Send your program correspondence to:*

☐ Me or ☐ My Alternate Contact or ☐ Both

Send information to me by*

☐ Email (enter address below) ☐ Post

APPLICANT POSTAL ADDRESS (if different to your residential address and you prefer to receive correspondence by mail)

Postal Address

Suburb | State | Postcode

Note: if you have asked that an alternate contact receive your information, please complete the alternate contact details on the back of this form.