

CAEP Plus Program

Assistive Technology (AT) Grant



Supported by the Department of Health
Government of **Western Australia**
Department of **Health**

CAEP Plus AT Grant Application Form

The **CAEP Plus AT Grant** will provide individuals with health, disability or aged related functional impairment with funding for essential equipment and AT that allows them to participate more independently within their homes and community.

The grant is available to individuals who are eligible for the Community Aids and Equipment Program (CAEP) to fund equipment and AT that is not currently available through CAEP.

More information on CAEP eligibility can be found on the Government of Western Australia website. Use the following link: <https://www.wa.gov.au/service/health-care/community-health-services/community-aids-and-equipment-program-caep> or contact your CAEP service provider.

For further information or to discuss the CAEP Plus AT Grant, please contact a member of the CAEP Plus Grants Team.

Submitting Grant Applications

CAEP Plus AT Grant applications can be submitted via email or mail.

To ensure the timely assessment of your grant application, please ensure:

- ALL relevant Grant Applicant and Allied Health Professional (AHP) sections of the application form are completed in full.
- The application is legible and has been signed as required.
- An appropriate allied health professional (AHP) clinical report is included.
- The application includes copies of TWO itemised quotes for the requested AT/equipment.
- Any additional contribution funds are available for the AT/equipment requested.

Contact Information

Website: www.ilaustralia.org.au/CAEP-grants

Phone: (08) 6202 4700

Email: caepplus@ilaustralia.org.au

Please use '**CAEP Plus AT Grant**' in the subject line of the email.

Postal Address:

CAEP Plus Grants

iLA

Freda Jacob House, 7 Tully Road

EAST PERTH

WA 6004

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Grant Applicant Section Part 1 of 3

Grant Applicant Section

Please complete both Part 1 and Part 2 of the Grant Applicant Section.

The following questions relate to the grant applicant, this is the person who is to benefit from the grant funding.

Part 1: Grant applicant details

Title:

Mr Mrs Ms Miss Other

First Name:

Last Name:

Gender:

Male Female Non-Binary
 Prefer not to say

Employment:

Yes
 No

Centrelink pension concession card (PCC) holder:

Yes PCC Expiry
 No PCC CRN

Relationship status:

Single Married/De-facto
 Divorced Widowed

How did you find out about the CAEP Plus Grant?

CAEP Service Provider Allied Health Professional GP Other

Contact details:

Address:

Suburb:

State:

Postcode:

Contact Phone Number:

Email:

Cultural details:

Main language spoken:

Do you require an interpreter?

Yes No

Are you of Aboriginal or Torres Strait Islander origin?

Yes Aboriginal Yes Torres Strait Islander Yes Both No Neither Prefer Not to Say

Alternative contact details:

First Name:

Last Name:

Address:

Suburb:

State:

Postcode:

Contact Phone Number:

Email:

Part 2: Grant Applicant Consent and Declaration

Privacy and Consent

Collection, Storage and Use of Personal and Sensitive Information:

The CAEP Plus Grant Team at Independent Living Assessment (iLA) are committed to respecting your privacy by complying with our obligations under the Privacy Act 1988, including the Australian Privacy Principles. You can expect that personal and sensitive information about you is only collected, stored, and used for the purposes of providing quality services to you.

For more information on how we manage your personal and sensitive information, visit the iLA website at: www.ilaustralia.org.au/about-us/our-policies/privacy-policy to view our Privacy Collection Statement, Contact Information and link to the full iLA Privacy Policy document.

Sharing of Personal and Sensitive Information

It may be necessary to share personal and sensitive information about you to other individuals and agencies to allow us to deliver services to you. This might include your authorised representative, health professionals, suppliers or government agencies. You may withdraw your consent for the CAEP Plus Grant Team to share your personal and sensitive information at any time by contacting us, however this may limit our ability to process your application.

Consent and Declaration: To be completed and signed by Grant Applicant (or representative).

- I consent to iLA collecting, storing, using and disclosing my personal and sensitive information for the purpose of the CAEP Plus Grant Program.
- I consent to the CAEP Plus Grant Team to share my personal and sensitive information with external parties for the purposes of considering, processing and/or finalising my grant application.
- I agree that additional personal and sensitive information can be sourced by and provided to the CAEP Plus Grant Team should it be required to support consideration of this application.
- I understand that I may withdraw my consent at any time and that withdrawing my consent means I can no longer receive the service.
- I confirm that all the information provided for this application is true and correct to the best of my knowledge.
- I confirm the equipment and assistive technology (AT) being purchased is agreed to and meets my needs.
- I understand that the grant must be approved before the AT is purchased.
- I understand that once I have received the AT purchased with the CAEP Plus Grant Program funding, I will own and be responsible for any future costs associated with insurance, repairs and maintenance.

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Grant Applicant Section Part 2 of 3



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Part 2: Grant Applicant Consent and Declaration (cont.)

Who is signing the grant applicant consent and declaration?

Grant Applicant Guardian/EPA Grant applicant representative

Full Name:

Signed:

Date:

Use a copy of your signature or an electronic signature

DD/MM/YYYY

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Allied Health Professional Section Part 1 of 5

Allied Health Professional Section

The following questions are to be completed by an allied health professional (AHP) who is recognised by CAEP for the prescription of the specific item (i.e. occupational therapist, physiotherapist, speech pathologist), who can confirm the person's functional disability, need and suitability of the item requested.

Part 1: CAEP Plus Eligibility

To check the CAEP eligibility of the grant applicant please contact their local CAEP service provider. To identify their local CAEP service provider, use the link below to locate their postcode in the Postcode Listings Document: www.wa.gov.au/system/files/2024-03/caep-postcode-listings-health-service-providers.pdf.

For more information regarding CAEP please visit: www.wa.gov.au/service/health-care/community-health-services/community-aids-and-equipment-program-caep.

Please provide the following information regarding the Grant Applicant

1. Is the applicant CAEP eligible? Yes No
2. Does the applicant have any equipment funded through CAEP? Yes No
3. Has the applicant had a previous CAEP Plus grant? Yes No
4. Does the applicant have existing CAEP funded equipment in the same category? Yes No
5. If yes, please list the category and equipment?
(e.g. Community access wheeled mobility device – mobility scooter).

6. Has this application been discussed/endorsed by a CAEP service provider? Yes No

7. If yes, please provide the CAEP service provider's contact details:

Provider Contact Details:

First Name:

Last Name:

Address:

Suburb:

State:

Postcode:

Contact Phone Number:

Email:

CAEP Region:

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Allied Health Professional Section Part 2 of 5

Part 2: Allied Health Professional Details and Declaration

I understand the CAEP Plus Team may contact me to verify the information I have provided in this grant application form. I declare all information I have provided on this grant application form is true and correct to the best of my knowledge.

Allied Health Professional contact details:

First Name:

Last Name:

Work Address:

Suburb:

State:

Postcode:

Contact Phone Number:

Email:

Position:

Qualification:

Signed:

Use a copy of your signature or an electronic signature

Date:

DD/MM/YYYY

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Allied Health Professional Section Part 3 of 5



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Part 3: Clinical Report

A Clinical Report must be provided to support the grant application. Additional relevant documentation may be attached if required. Completing the fields below can comprise the Clinical Report.

Please Note: The answer boxes below have a limited character capacity. If you require more space to provide your responses, please use the additional 'Report Information Box' at the end of Part 3: Clinical Report. Alternatively, a separate Clinical Report that addresses the fields below can be attached.

1. Disability / Diagnosis (include date of onset):

2. Social Situation:

3. Mobility:

4. Functional difficulties related to the AT requested:

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Allied Health Professional Section Part 3 of 5 (cont.)



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5. How is the AT essential to enable the individual to participate more independently in their home and/or community?

6. What AT options were considered, including the outcome of trials and why the preferred item is more suitable than other options considered?

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Allied Health Professional Section Part 3 of 5 (cont.)



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7. Is training in the use of the AT required? Yes No

If Yes, what is the agreed follow-up plan for training and who will complete this?

8. Why can't the equipment be accessed through CAEP?

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Allied Health Professional Section Part 3 of 5 (cont.)



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9. Is there any other information relevant to consideration of this application?

Clinical Report Prepared By:

First Name: Last Name:

Qualifications:

Work Address:

Suburb: State: Postcode:

Contact Phone Number: Email:

Position: Qualification:

Signed: Date:
Use a copy of your signature or an electronic signature *DD/MM/YYYY*

When is the best time to contact you? Please indicate days of the week and times.

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Allied Health Professional Section Part 3 of 5 (cont.)



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Additional Report Information:

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Allied Health Professional Section Part 4 of 5



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Part 4: AT and Equipment Request Details

TWO quotes for the requested AT/equipment must accompany the application. In circumstances where only one quote is provided, rationale must be provided.

The supplier quotes must detail:

- The grant applicant's full name.
- All relevant AT/equipment specifications as recommended by the prescribing allied health professional.
- GST (where applicable).
- Delivery/freight charges (where applicable).

Quote 1

Reason for selection:

Item	Supplier	Cost ex. GST	GST	Total cost inc. GST
Delivery costs (if applicable)				
		Total		

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Allied Health Professional Section Part 4 of 5 (cont.)



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Quote 2

Reason for selection:

Item	Supplier	Cost ex. GST	GST	Total cost inc. GST
Delivery costs (if applicable)				
		Total		

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Allied Health Professional Section Part 5 of 5



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Part 5: Grant Funding Requested – What is the Preferred Quote?

It is expected that the preferred quote will be for the lower price. Where the more expensive quote is preferred, a sound clinical rationale, pragmatic and/or ethical, must be provided to support this decision.

Preferred Quote Selection: Quote 1 Quote 2

Detail the rationale for the Quote Selection:

Grant Request Details:

What is the total cost of AT/equipment, excluding GST? A\$

What is the delivery/freight charge? A\$

Will the grant applicant be contributing to the cost of the AT/equipment? Yes No

If yes, what is the amount? A\$

Will another entity be contributing to the cost of the AT/equipment? Yes No

If yes, what is the name of the entity?

Who is the contact person for the entity? Please provide full name and contact details.

First Name: Last Name:

Work Address:

Suburb: State: Postcode:

Contact Phone Number: Email:

What amount is the entity contributing? A\$

What is the total grant amount being requested (including the cost of the AT/equipment and delivery/freight charges)? A\$

Is this an urgent funding request? Yes No

If Yes, why?

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Additional Information if Required

Please use the space below to add any additional information. If it refers to a particular section and question, please state which and then continue with your added information.