THERMOREGULATORY DYSFUNCTION ENERGY SUBSIDY SCHEME APPLICATION FORM

For further information:

SECTION 1 – APPLICANT DETAILS

First Name: 
Middle Name(s): 
Surname: 
Phone Number (business hours):
Date of Birth: / / 

Home Address: 
(Where the energy consumption is being used) 
Postcode 

Postal Address: 
(If same as Home Address write ‘As above’) 
Postcode 

Email Address: 

OFFICE USE ONLY

Application ID
SECTION 2 – CONCESSION CARD DETAILS OF APPLICANT

Type of Concession Card

- Pensioner Concession Card
- Health Care Card*
- Health Care Interim Voucher

* Does not include a Commonwealth Seniors Health Card

Concession Card No:

Who Is The Patient?

Are you suffering from thermoregulatory dysfunction?  

NO  [ ] (Go to Section 3)  

YES  [ ] (Go to Section 4)

SECTION 3 – DEPENDANT DETAILS

This information is required where this application is being submitted in relation to a person suffering from thermoregulatory dysfunction who is living at the applicant’s address

Dependant’s Full Name

First Name:  
Middle Name(s):  
Surname:  
Relationship to you:  
Date of Birth: / /        

SECTION 4 – BANK ACCOUNT DETAILS

Must be a Savings or Cheque Account. The subsidy will be paid electronically to this account.

Bank or Financial Institution (e.g. ANZ) 

Branch of Bank (e.g. Innaloo)  

BSB Number (6 digits in total)  

Account Number (up to 9 digits only)  

The name of the person(s) who holds this account (as it appears on the bank statements)  

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SECTION 5 – AUTHORISATION AND DECLARATION

Read, sign and date the authorisation and declaration.

I authorise –
   the Office of State Revenue (‘OSR’) to use Centrelink Confirmation eServices to perform a Centrelink/DVA enquiry of my Centrelink or Department of Veterans’ Affairs Customer details and concession card status in order to enable the business to determine if I qualify for a subsidy.
   the Australian Government Department of Human Services (‘the department’) to provide the results of that enquiry to OSR.

I understand that –
   the department will use information I have provided to OSR to confirm my eligibility for the subsidy and will disclose to the OSR personal information including my name, address, payment and concession card type and status.
   this consent, once signed, remains valid while I am a customer of OSR unless I withdraw it by contacting OSR or the department.
   I can obtain proof of my circumstances/details from the department and provide it to OSR so that my eligibility for the subsidy can be determined.
   if I withdraw my consent or do not alternatively provide proof of my circumstances/details, I may not be eligible for the subsidy provided by OSR.

I hereby declare that –
   this subsidy is to offset the cost of energy associated with temperature control for myself, or my dependant, at the address shown on page one.
   I am not currently claiming a Thermoregulatory Dysfunction Energy Subsidy for myself, or my dependant, at another address.
   I will notify the OSR in writing of any changes that affect either the validity of this application or my entitlement to the concession card.
   I understand that the Public Utilities Office will conduct a review of subsidy recipients on a regular basis. To obtain the subsidy I hereby authorise the release of my medical records to the Public Utilities Office for the purposes of review. If I receive a subsidy on the basis of incorrect information I will be required to repay any subsidy paid.
   all particulars in this form are, to the best of my knowledge and belief, true and accurate.

APPLICANT

Name of Applicant: ________________________________ (please print)
Signature of Applicant: ________________________________
Date: _____/_____/_______

PATIENT

Name of Patient: ________________________________ (please print)
Signature of Patient: ________________________________
Date: _____/_____/_______
SECTION 6 – MEDICAL AUTHORISATION

TO BE COMPLETED BY A GENERAL PRACTITIONER OR SPECIALIST MEDICAL PRACTITIONER

For the purposes of this subsidy, thermoregulatory dysfunction is defined as a significant loss of a person’s capacity to control body temperature when exposed to extremes of environmental temperatures.

To qualify for the Thermoregulatory Dysfunction Energy Subsidy, the patient must:

- be certified by a treating doctor who has been the patient’s treating doctor for at least three months; and
- be assessed as meeting two of the three qualifying criteria.

<table>
<thead>
<tr>
<th>Doctor to complete - Name of condition causing thermoregulatory dysfunction</th>
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<tbody>
<tr>
<td>e.g. Multiple sclerosis, stroke, burns</td>
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<tr>
<th>Doctor to complete - Qualifying Criteria</th>
<th>Tick</th>
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<tr>
<td><strong>1. Autonomic system dysfunction.</strong></td>
<td></td>
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<tr>
<td>Medical condition with an evidence-based association with the deterioration of this condition in temperature extremes. For example, severe cases of spinal cord injury, stroke, brain injury, neurodegenerative disorders, multiple sclerosis and familial disautonomia.</td>
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<tr>
<td><strong>2. Loss of skin integrity or loss of sweating capacity.</strong></td>
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<tr>
<td>For example, significant burns of greater than 20% of body surface area, severe inflammatory skin conditions and some rare forms of disordered sweating.</td>
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<tr>
<td><strong>3. Objective reduction of autonomic regulation and physiological functioning at extremes of environmental temperatures.</strong></td>
<td></td>
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<td>For example, excessive sweating, heart rate increases or changes in blood pressure resulting in dehydration, dizziness or fainting.</td>
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<tr>
<th>Doctor to complete - Permanent Condition</th>
<th>Tick</th>
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<tbody>
<tr>
<td>Provide a copy of the medical report confirming the condition, and that it is a permanent condition. Tick the box if the patient has:</td>
<td>☐</td>
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<tr>
<td>- Severe autonomic dysfunction, specifically:</td>
<td></td>
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<td>o High spinal transection;</td>
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<td>o Familial disautonomia; or</td>
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<td>o Progressive neuro-genetic degenerative conditions.</td>
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<td>- Extensive loss of skin integrity, with burns to over 50 per cent of the body surface area</td>
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<td>and the medical condition will affect their thermoregulatory control permanently.</td>
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</tbody>
</table>
I certify that the Thermoregulatory Dysfunction qualifying criteria has been met by: 

(Name of Patient)

I have sighted the following confirmatory documentation regarding the diagnosis.

Tick appropriate box

- [ ] Specialist’s Report
- [ ] Hospital Discharge Summary

I hereby acknowledge the applicant/patient’s consent to allow the Public Utilities Office to access the medical records for the purposes of reviewing and auditing the subsidy and will cooperate in making the records available.

Signature of doctor: ___________________________ Date: __/__/____

The doctor must complete all of the following information in full:

Please print clearly

Doctor’s Surname:

Doctor’s Given Name:

Provider Number:

Postal Address:

Email Address:

Phone Number:

Add Stamp (if available)

PLEASE RETURN THE COMPLETED FORM TO:

OFFICE OF STATE REVENUE
GPO BOX T1600
PERTH WA 6845