

Part A:

If you are an Australian citizen or permanent resident 21 years or older and you meet one of the following, you are eligible for a hearing services Voucher

Please select your eligibility type.

Tick relevant box and provide number:

- Centrelink Pensioner Concession Card
- Centrelink Sickness Allowance
- DVA Pensioner Concession Card
- White Health Repatriation Card (for hearing loss)
- Gold Health Repatriation Card
- Dependant person of one of the above categories (see below)
- A member of the Australian Defence Forces

CRN, DVA file or Service Number (eg NX number)

If claiming **dependant** status please provide the **CRN or DVA file number and name** of the eligible card holder:

Name

Title Last Name (Please Print)

First Names Sex (M/F)

Date of birth Telephone Number

Postal Address

State

Post Code

Choice of Provider

The Office of Hearing Services produces a directory of the hearing service providers that are located closest to your home. If you would prefer to attend a provider in a different location that you might attend regularly eg, relative's place or other city or town, the Office will provide an additional directory for this area.

Suburb

Postcode

Alternative contact

If you wish to nominate a friend or family member as an alternative contact, please provide the details below.

Name

Telephone number

By signing this form I consent to the Office of Hearing Services storing the information provided on this form and disclosing information to Centrelink, the Department of Veterans' Affairs and the Australian Defence Force (if appropriate) to confirm my eligibility for hearing services and for these Agencies to disclose information to the Office of Hearing Services in confirmation of my eligibility. I understand that the information provided on this form may be supplied to Medicare Australia for the purpose of payment to hearing service providers of service claims.

I understand that my hearing service provider will maintain records of my clinical needs and treatment and that these clinical records may be made available to the Office of Hearing Services for audit and review purposes.

Applicant's signature

Date

Part B: Referral Details

Your doctor or hearing services provider must complete this part

New Applicant

If the applicant **HAS NOT** previously received services under the Australian Government Hearing Services Program, a **Doctor must sign and complete this part.**

Return Client

If the applicant **HAS** previously received services under the Australian Government Hearing Services Program, a **Doctor OR a hearing services provider can sign and complete this part.**

Return Client Number (if applicable)

Details of Referrer (Doctor/Hearing Services Provider)

Title Name (Please Print)

Telephone Number

Address

State

Post Code

General Practitioner/OHS Practitioner number

Are there any medical contra-indications to the fitting of a hearing aid/s.

Yes No

Signature of Referrer

By signing the form, I consider that the applicant's hearing status and/or hearing aid fitting is in need of assessment or review.

Date

Part C: Additional Information (optional)

The following information is used for planning and reporting purposes or to assist in communicating with you. Your response is optional, but your assistance would be appreciated.

Do you speak a language other than English at home?

- No, only English
 Yes, other (please specify)

Are you of Aboriginal or Torres Strait Islander origin?

- No
 Yes, Aboriginal/Torres Strait Islander

For Aged Care Home Residents

If you are a resident of an Aged Care home, would you like notification about your Voucher to be sent to another person for example the Director of nursing.

- Yes
 No

Aged Care Home/Name of Contact

(Address if different to above)

<input type="text"/>	
<input type="text"/>	
<input type="text"/>	<input type="text"/>
State	Post Code

For more information contact:

1800 500 726 or (TTY) 1800 500 496

email: hearing@health.gov.au

Or visit the Office of Hearing Services Website at:
www.health.gov.au/hear



Australian Government

Department of Health and Ageing
Office of Hearing Services

The Australian Government
Hearing Services Program

Please post the completed form to:

Applications
Mail Drop Point 113
Office of Hearing Services
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Application for a Hearing Services Voucher

www.health.gov.au/hear
email: hearing@health.gov.au