ACT Government | Lifetime Care and Support Scheme

1 Constitution Avenue
Canberra City ACT 2601
Ph: 13 22 81
email: ltcss@act.gov.au

Application Form – Workplace Accidents

To be completed by Insurer/Self-Insurer or injured worker

If you have any questions, call ACT LTCS Lifetime Care and Support Commissioner (the LTCS Commissioner) on 132281 or email ltcss@act.gov.au.

Workers with injuries that arose out of or in the course of their employment which have the ACT as the Territory of connection; and which also meet the catastrophic injury criteria under the Lifetime Care and Support (LTCS) Scheme will have their treatment and care needs met under the LTCS Scheme. The catastrophic injuries include:

- brain injury
- spinal cord injury
- multiple amputations or specific unilateral amputations
- burns
- permanent blindness

If the worker's injuries meet the catastrophic injury criteria under the LTCS Scheme as defined in the LTCS Guidelines and the injury is work related, the worker will be accepted as an interim participant into the LTCS Scheme. The worker's reasonable and necessary treatment and care needs will be covered under the LTCS Scheme. The Insurer or Self-Insurer will continue to administer all other types of compensation that may be payable.

About this form

This form may be completed by the injured worker, or the insured worker's Insurer/Self-Insurer. The medical certificate needs to be completed by the worker's treating specialist before it is lodged.

- If the form is completed by the injured person (or a family member, parent or guardian of the injured person), **All** Parts in this form (except Parts 7 and 9) should be completed by the injured person, family member, parent or guardian. The parent or guardian must be over 18 years old. Part 9 should be completed by a member of the treating health team.
- If the form is completed by insurer or self-insurer, Parts 1,2,4,5,6 & 7 should be completed by the insurer or self-insurer and Part 8 should be completed by the injured person or the injured person's family member, parent or guardian. The parent or guardian must be over 18 years old. Parts 9 should be completed by a member of the treating health team.

Where do I send this form when it is completed?

Lifetime Care
GPO BOX 4052
SYDNEY NSW 2001

Ph: 1300 738 586 Fax: 1300 738 583 Email: requests@icare.nsw.gov.au

AF2016-48 made under the Lifetime Care and Support (Catastrophic Injuries) Act 2014, s 98

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What will happen next?

- The ACT LTCS Commissioner (the ACT Commissioner) or its administration partner the NSW Lifetime Care and Support Authority (**the NSW LTCS Authority** also known as **Lifetime Care**) will review the form to see if it is complete and whether additional information is required. We will contact the Insurer/ Self-Insurer or medical provider if that is the case.
- The LTCS Commissioner will advise the injured worker, Insurer/Self-Insurer and employer of our decision in writing.
- If the work injury meets the eligibility criteria, the LTCS Scheme will pay hospital, medical, rehabilitation and attendant care expenses from the date of acceptance into the Scheme, where these are reasonable and necessary and related to the injuries caused by the work accident. The Insurer/Self-Insurer will continue to administer all other types of compensation that may be payable.

Insurer/Self-Insurer completing this form

Liability: ☐ Liability accepted Date liability accepted ☐

Is the injured person, their family or guardian aware of the decision? ☐ Yes ☐ No

Information for the Worker

Your privacy: how we collect use and disclose your personal and health information

Information about the accident

The LTCS Commissioner and the LTCS Authority need information about the accident and your injuries to determine if your injury falls within the criteria of the LTCS Scheme. This may include information collected from or about other people involved in the accident, including witnesses, and the response, including from emergency services.

The LTCS Commissioner is authorised by law to seek and share information about the accident, and about your injuries and treatment, with any insurance company involved.

Information about your health

The LTCS Commissioner and NSW LTCS Authority will also collect health information about you from other people, including health service providers. Health information may include information about your workplace injury, pre-accident and general medical information about you.

Information about you

If your application is successful, the LTCS Commissioner and the NSW LTCS Authority need information about your care, support and housing situation so that your needs can be met and the program can be well-managed. This may include information collected from, or about, other people involved in your life, such as family, friends and carers.

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Information about your treatment and care needs

If your application is successful, you will become a participant in the LTCS Scheme. The NSW LTCS Authority will then need to communicate with a range of organisations and other people about your ongoing treatment and care needs. This may involve collection of information from and disclosure to any of the following: Your family or guardian; health service providers; other service providers; your case manager or other community/social workers, educational facilities (e.g. school or TAFE), other government agencies, employers, lawyers and insurers. Any of these may also engage contractors or service providers who may need to collect, use or disclose your personal or health information.

If there is a dispute

If there is a dispute about the nature of your injuries or your treatment and care, the NSW LTCS Authority may need to share your information with the Insurer/Self-insurer, Independent Medical Officers, other government agencies and solicitors. They may also require additional information to help them in their assessment.

Other uses and disclosures

In exceptional circumstances, NSW LTCS Authority may need to provide personal or health information to third parties; for example to the police for law enforcement, or in emergencies. The LTCS Authority may also use information about participants in the Scheme for program evaluation and research, and this may be undertaken by contractors, although research results will only be published in de-identified form or with your express consent.

Your privacy rights

You may request access to personal or health information held about you by the NSW LTCS Authority at any time. Please contact your LTCS Authority Coordinator if you wish to access your information. If you have concerns about LTCS Authority sharing your personal or health information with a particular service or family, please contact LTCS Authority to discuss the issue.

Translating and Interpreting Service

If you need an interpreter to help you read and/or fill in this form, a language assistance service is available by phoning the Translating and Interpreting Service (TIS) on 13 14 50.

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1. PERSONAL DETAILS OF THE INJURED PERSON

Title | Surname | First Name(s)

If known by any other names please list below

Gender ☐ Male ☐ Female

Date of Birth | Compensation Claim number

Home Phone | Mobile Phone | Email address

Residential Address

Street *Suburb* *State* *Postcode*

Postal Address (if different)

Suburb *State* *Postcode*

Is an interpreter required? ☐ No ☐ Yes – complete interpreter declaration on page 7.

Language

2. PERSONAL DETAILS OF THE FAMILY MEMBER OR OTHER CONTACT PERSON

Title | Surname | First Name(s)

Relationship to injured person | Home phone | Work phone

Mobile Phone | Email address

Address

Street *Suburb* *State* *Postcode*

Is an interpreter required? ☐ No ☐ Yes Language

3. SOLICITOR CONTACT DETAILS (IF APPLICABLE)

Title | Surname | First Name(s)

Role / title | Company | Phone

Mobile Phone | Email address

Mailing Address

Street *Suburb* *State* *Postcode*

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4. EMPLOYER CONTACT DETAILS

Title | Surname | First Name(s)

Employer Role / title | Company | Phone

Mobile Phone | Email address

Mailing Address

Street *Suburb* *State* *Postcode*

Is an interpreter required? ☐ No ☐ Yes Language

5. ACCIDENT DETAILS

Date of the accident | Nature of the accident

Was a motor vehicle involved in the accident (including forklifts)? ☐ Yes ☐ No

Has a CTP claim or Lifetime Care and Support Application (for motor accident) been submitted?
☐ CTP ☐ Lifetime Care ☐ No

CTP Insurer's name | Claim number | Insurer's contact person

6. INJURY DETAILS

6.1 What are the person's injuries as a result of the accident?

☐ Brain injury ☐ Spinal cord injury ☐ Amputation/s ☐ Burns ☐ Blindness

6.2 Other injuries

6.3 Did the injured person need an ambulance? ☐ Yes ☐ No

6.4 Did the injured person go to a hospital after the accident? ☐ Yes ☐ No

Which hospital? | Date attended

6.5 Was the injured person admitted to a hospital or rehabilitation facility? ☐ Yes ☐ No

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Which hospital? | Date admitted or treated

Which hospital? | Date admitted or treated

Which hospital? | Date admitted or treated

6.6 Has the injured person been discharged from hospital? ☐ Yes ☐ No

Which hospital? | Date discharged

7. INSURER OR SELF- INSURER CONTACT

Title | Surname | First Name(s)

Role / title | Company | Phone

Mobile Phone | Email address

Mailing Address

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8. AUTHORITY TO COLLECT YOUR INFORMATION

Please read carefully before signing.

This Authority must be signed by the injured person, or the injured person's relative, friend, guardian or other legal representative. The person who signs this form must be over 18 years of age.

I authorise the LTCS Commissioner of the ACT and the NSW LTCS Authority to collect from and disclose information to the parties listed below personal and health information about me relevant to my injury, treatment, rehabilitation and care needs, and to any related compensation claim. Relevant parties may be:

- a relative, friend, guardian or other legal representative
- a health care practitioner or service provider, including the ambulance service and hospitals
- a social or community worker
- a legal practitioner or an insurance company involved in my case
- Commonwealth, State or Territory government departments or agencies involved in my case,

I understand that information obtained under this Authority may include pre-accident and general medical information. I understand that my information may be used for the purposes explained in the section of this form headed *Your Privacy: how we collect use and disclose your information*.

Name of injured person			
Signature of injured person		Date	

Complete this section if another person is completing the Declaration and Authority on behalf of the injured person

Name of person			
Signature of person		Date	
Relationship to injured person			
Reason why the injured person could not sign			

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9. MEDICAL CERTIFICATE

Surname/family name of injured person

First name(s) of injured person

Date of Birth

Gender ☐ Male ☐ Female

Was the injury described below caused by the workplace accident? ☐ Yes ☐ No

Are the injuries consistent with the circumstances of the workplace accident described to you?
☐ Yes ☐ No

Does the injury meet the severe injury criteria as set out below? ☐ Yes (complete boxed section(s) below)
☐ No

Please complete all the applicable severe injury categories.

Brain injury

I certify that the injured person has sustained a brain injury caused by the workplace accident. The brain injury meets the following criteria, as outlined below:
Complete both sections below:

☐ The duration of PTA is greater than 1 week.

Number of days in PTA *Attach PTA scoring sheets*

If the PTA score is not available or not applicable (for example the injured person has a penetrating brain injury)

☐ There is evidence of a very significant impact to the head causing coma for longer that one hour. Where coma has been documented, attach a copy. If not, describe in the box below how this was determined.

OR

☐ There is significant brain imaging abnormality, e.g. penetrating injury. Describe in the box below why the abnormality is significant.

Attach a copy of the imaging report

AND

☐ The injured person has scored 5 or less on any of the items on the FIM, due to the brain injury, within the last month and **I agree with this FIM assessment**.

Attach FIM worksheets

Spinal cord injury (permanent sensory / motor deficit or bladder / bowel dysfunction)

I certify that the injured person has sustained a spinal cord injury caused by the workplace accident. The spinal cord injury meets the spinal cord injury criteria as outlined below:

The spinal cord injury is an acute traumatic lesion of the neural elements (spinal cord and cauda equina) resulting in permanent sensory deficit, motor deficit or bladder/bowel dysfunction

Neurological (SCI) level ASIA impairment scale

Attach ASIA score sheet

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Amputation/s

I certify that the injured person has sustained amputation/s (or equivalent impairment) caused by the workplace accident. The amputation is one of the following types of amputations, as outlined below:

Complete either Multiple amputations or Unilateral amputation below:

1. Multiple amputations

Multiple amputations of the upper and/or lower extremities, meaning that there is more than one of the following types of amputation at or above the level of:

- a short transtibial or standard transtibial amputation, as defined by the loss of 50% or more of the length of the tibia. This includes all other amputations of the lower extremity (such as knee disarticulation or transfemoral amputation) above this level; ☐ Right ☐ Left
- a thumb and index finger of the same hand, at or above the first metacarpophalangeal joint. This includes all other amputations of the upper extremity (such as below-elbow or above-elbow amputation) above this level. ☐ Right ☐ Left

2. Unilateral amputation

The amputation is one of the following:

1. forequarter amputation (complete amputation of the humerus, scapula and clavicle) or shoulder disarticulation; ☐ Right ☐ Left
2. hindquarter amputation (hemipelvectomy by trans-section at sacroiliac joint, or partial pelvectomy; ☐ Right ☐ Left
3. hip disarticulation (complete amputation of the femur); or ☐ Right ☐ Left
4. short transfemoral amputation as defined by the loss of 65% or more of the length of the femur. ☐ Right ☐ Left

Permanent blindness

I certify that the injured person has sustained permanent blindness caused by the workplace accident. The loss of sight meets one of the following criteria, as outlined below:

☐ a) visual acuity on the Snellen Scale or equivalent after correction by suitable lenses is less than 6/60 in both eyes; or

☐ b) field of vision is constricted to 10 degrees or less of arc around central fixation in the better eye irrespective of corrected visual acuity (equivalent to 1/100 white test object); or

☐ c) a combination of visual defects resulting in the same degree of visual loss as that occurring in (a) or (b) above.

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Burns

I certify that the injured person has sustained full thickness burns caused by the workplace accident. The injury meets one of the following criteria, as outlined below:

☐ The injured person is a child under 16 that has full thickness burns greater than 30% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.

OR

☐ The injured person has full thickness burns greater than 40% of body, or full thickness burns to the hand, face or genital area, or inhalation burns causing long term respiratory impairment.

AND

☐ The injured person has a score of 5 or less on any of the items on the FIM, due to the burns, within the last month and **I agree with this FIM assessment**.

Attach FIM worksheets

I declare that I have examined the nominated patient and to the best of my knowledge the information provided here is true and correct.

Name of treating specialist

Qualification

Signature

Provider Number

Date

Address

Phone

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Checklist

Before sending this form to Lifetime Care (also known as NSW LTCS Authority) please ensure that you have completed the following steps

☐ **Medical Certificate and FIM, PTA or ASIA worksheets completed and attached**

☐ **A copy of the Application Form and any accompanying information have been made for your own records**