

# NSW Life Support Rebate



## Application form: Retail customers

### How to complete this form

Complete this form to apply for the Life Support Rebate. This rebate helps people who use, or live with people who use, energy-intensive life support equipment, to pay their energy bills.

Please read carefully:

- The **Applicant** is the energy account holder. The Applicant will need to complete page 2 of this form.
- The **Patient** is the user of the life support equipment. The Patient will need to complete the declaration on page 3 of this form.
- The **Medical Practitioner** who treats the Patient will need to review the patient details, and complete the medical practitioner sections on pages 3 and 4 of this form.

Approved life support equipment is listed on page 5.

The completed form must be sent to your energy retailer.

If you need assistance to complete this form, please contact your energy retailer.

### Submitting this form to your energy retailer

Before sending this form ensure that:

- all details supplied are verified and correct
- all sections of this form are filled out
- all conditions listed in the declarations are signed and agreed
- the medical practitioner has signed and completed all relevant sections on page 3 and 4.

## Applicant details

The applicant must be the primary account holder of the electricity account at the applicant’s and patient’s primary place of residence. An application expires after 4 years. An applicant must resubmit this application every 4 years or when the medical equipment of the patient or the primary place of residence changes.

|                                  |  |
|----------------------------------|--|
| First name:                      |  |
| Last name:                       |  |
| Electricity account number:      |  |
| National Meter Identifier (NMI): |  |

Your NMI can be found on your electricity bill. It starts with 4 and is 11 digits long with no letters or symbols.

## Applicant declaration and authorisation statement

I, the applicant, understand that:

- It is my responsibility to ensure that all the information provided in this application is, to the best of my knowledge, true and correct and I will notify my energy retailer, in a timely manner, of any changes to my information.
- I may be required to provide additional information about my eligibility.
- I can only receive the NSW Life Support Rebate once per financial year, per equipment type.
- By signing this document, I can confirm that I have read and understood the Privacy Collection Notice (available at [www.energy.nsw.gov.au/privacy-collection-notice](http://www.energy.nsw.gov.au/privacy-collection-notice)).
- It is a criminal offence under the *Crimes Act 1900* to provide false or misleading information.

Applicant signature:

Date:

### Consent for person to act on the applicant’s behalf (optional)

Only complete this section if you would like someone to act on your behalf in relation to this application.

I authorise

who can be contacted by phone on

or via email at

to communicate with my energy retailer on my behalf about this application.

**I understand that I can withdraw this consent at any time by contacting my retailer.**

### Consent to contact (optional)

☐ I consent to my energy retailer contacting me about my experience applying for the rebate.

# Patient details and medical declaration

This part of the form should be filled out by the patient and the registered medical practitioner where indicated.

## Patient details

This section must be completed by the patient.

|                                                  |  |
|--------------------------------------------------|--|
| Name of patient who uses life support equipment: |  |
| Address of patient:                              |  |
| Patient daytime contact number:                  |  |

- ☐ I, the patient, agree for my information to be shared with the applicant's energy retailer.
- ☐ For the purposes of administering this rebate, I consent to the release of the medical information in this application provided by my medical practitioner to the applicant's energy retailer.

Patient signature:

Date:

## Medical practitioner details

This section must be completed by the patient's regular registered medical practitioner. The patient must have been treated by this practitioner for more than 3 months.

|                                                                              |  |
|------------------------------------------------------------------------------|--|
| Practitioner name:                                                           |  |
| Provider number:                                                             |  |
| Name of place where patient was reviewed (hospital/clinic/practice):         |  |
| Phone number of place where patient was reviewed (hospital/clinic/practice): |  |

Continued over page

Approved life support equipment prescribed for the patient

The patient’s medical practitioner is required to select the relevant check box/es below. To meet the criteria for the NSW Life Support Rebate, the patient must have been assessed by a registered medical professional to verify that the use of the approved life support equipment is required at their principal place of residence. See page 5 for more information on approved life support equipment.

Medical practitioner declaration

I certify that the patient requires the use of:

| Check box                | Equipment                                   | Qualification                                                                                   |
|--------------------------|---------------------------------------------|-------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | Oxygen concentrators (full-time)            | Machine is used continuously for 24 hours a day                                                 |
| <input type="checkbox"/> | Oxygen concentrators (part-time)            | Machine is used less than 24 hours a day (part-time)                                            |
| <input type="checkbox"/> | Positive airway pressure device (full-time) | Machine is used continuously for 24 hours a day                                                 |
| <input type="checkbox"/> | Positive airway pressure device (part-time) | Machine is used less than 24 hours a day (part-time)                                            |
| <input type="checkbox"/> | Enteral feeding pump                        | –                                                                                               |
| <input type="checkbox"/> | External heart pump                         | –                                                                                               |
| <input type="checkbox"/> | Home dialysis                               | –                                                                                               |
| <input type="checkbox"/> | Phototherapy                                | –                                                                                               |
| <input type="checkbox"/> | Power wheelchairs                           | Patient must be classified as a quadriplegic<br><b>Note:</b> does not include mobility scooters |
| <input type="checkbox"/> | Total parenteral nutrition pump             | –                                                                                               |
| <input type="checkbox"/> | Ventilators                                 | <b>Note:</b> does not include nebulizers, humidifiers or vaporizers                             |

- ☐ I, the medical practitioner, declare that all information, including the patient’s address as written on page 3, provided in this application is, to the best of my knowledge, true and correct.
- ☐ I, the medical practitioner, consent to the energy retailer contacting me to confirm the accuracy of the personal and health information provided in this form.

Signature of medical practitioner:

Date:

Reset

## Approved life support equipment

| Equipment type                                                                  | Equipment examples*                                                                             | Daily rate (excludes GST)                                       |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| Oxygen concentrators (full-time)                                                | Devilbiss, etc                                                                                  | \$3.1096 (machine must be used continuously for 24 hours a day) |
| Oxygen concentrators (part-time)                                                | Devilbiss, etc                                                                                  | \$1.8493 (machine is in use for less than 24 hours a day)       |
| Positive airway pressure device (full-time)                                     | Continuous positive airway pressure, bilevel or variable positive airway pressure               | \$0.7096 (machine must be used continuously for 24 hours a day) |
| Positive airway pressure device (part-time)                                     | Continuous positive airway pressure, bilevel or variable positive airway pressure               | \$0.3589 (machine is in use for less than 24 hours a day)       |
| Enteral feeding pump                                                            | Kangaroo ePump, Companion-Abbott Flexiflow, Patro Enteral Pump                                  | \$0.4411                                                        |
| External heart pump                                                             | Left ventricular assist device                                                                  | \$0.1096                                                        |
| Home dialysis                                                                   | Haemodialysis or peritoneal automated cyclers machines – for example: Fresenius, Gambro, Baxter | \$1.5397                                                        |
| Phototherapy equipment                                                          | Blue light therapy                                                                              | \$3.6795                                                        |
| Power wheelchairs for quadriplegics<br>Note: does not include mobility scooters | Quickie, Zippie, etc.                                                                           | \$0.3014                                                        |
| Total parenteral nutrition pump                                                 | Volumatic Pump, Flowguard pump                                                                  | \$0.8411                                                        |
| Ventilators<br>Note: does not include nebulizers, humidifiers or vaporizers     | LTV Series Ventilators, Breas Vivo Series, Respironics Lifecare PLV-100, Iron Lung, etc         | \$3.6795                                                        |

\*List of brand names against each piece of equipment has been included for information only and is not exhaustive