

This application must be submitted to: **Lifetime Support Authority, Ground Floor, 30 Wakefield Street, Adelaide, SA, 5000** – Telephone: (08) 8463 6131 or emailed to LSANotifications@sa.gov.au

Application for participation in the Lifetime Support Scheme.

The Lifetime Support Scheme (LSS) provide's necessary and reasonable treatment, care and support for people who suffer serious eligibile injuries in a motor vehicle accident in South Australia, regardless of fault. It applies to accidents that occured on or after 1 July 2014.

The injuires covered by the scheme include:

- brain injuries
- spinal cord injuries
- permanent blindness
- whole limb or multiple amputations
- very serious burns

Applications and supporting documentation will be assessed against the specific criteria in the legislation and the Lifetime Support Scheme Rules which can be viewed at: www.lifetimesupport.sa.gov.au

Who completes this application?

This application must be made by the injured person, someone with lawful authority on their behalf, or the insurer/nominal defendant.

You must be over the age of 18 to complete this form.

LSA Staff Assistance

Is this application being completed with the assistance of a Lifetime Support Authority staff member?

Yes No

Name of Lifetime Support Authority staff member assisting with the completion of this application (if applicable)

Aboriginal and/or Torres
Strait Islander origin?

Yes No

Preferred form of written
communication

Email Post

Preferred
phone number

Mobile
Home
Work

If the injured person is a **child under 18 years of age**, are you a:

Parent; or

Guardian (If you are a Guardian, please attach evidence of Guardianship)

If you are making this application on behalf of an injured person who is **18 years of age or older**, under which category do you have lawful authority?

Close relation

Legal Guardian (please attach evidence of Guardianship)

Substitute Decision Maker through Power of Attorney or Advanced Care Directive

3. Workers Compensation

Did the accident happen while the injured person
(applicant) was working?

Yes
No
Don't Know

If yes, has a workers compensation claim been
submitted?

Yes
No

If the motor vehicle accident happened while the injured person was working:

Employer

Workers Compensation Claim Number

Employer's Address

Name of workers compensation scheme

Name of workers compensation scheme contact
person

Workers compensation scheme contact phone
number

4. Compulsory Third Party

Has a Compulsory Third Party (CTP) claim been submitted?

Yes

No

Don't Know

If Compulsory Third Party has been submitted:

Insurer's name

Claim number

Insurer's contact person

Insurer's Phone Number

Insurer's address

5. Accident Details

SAPOL Vehicle Collision Report Number

Date of Accident (DD/MM/YYYY)

Time of Accident (am/pm)

Location of Accident (Street/Road/Highway, Nearest Intersection, Location, State, GPS Coordinates)

Injured person's (applicant's) part in accident (eg. Passenger (front/rear), Driver, Cyclist, Pedestrian, Motorcycle rider, Pillion passenger etc.)

Police Station, Attending Officer (if known)

Injured person's (applicant's) description of the accident (eg. position of the injured person in relation to the vehicles involved, how the accident happened etc.)

6. Details of Motor Vehicles Involved in the Accident

Was the vehicle registered?

Yes

No

Don't know

State of Vehicle Registration

Number plate

Year of Manufacture

Colour of Vehicle

Make/Model of Vehicle

Type of Vehicle (eg. sedan/hatch)

Description of damage caused to the vehicle

Driver's name

Driver's license number

Was the injured person (applicant) in this vehicle when the motor vehicle accident occurred? (if known)

Yes

No

Number of people in the vehicle

Passenger names

7. Details of any Witness

Witness to the Accident? If yes, record below.

Title

First name(s)

Surname/family name

Address

Relationship to the injured person

Mobile Phone Number

Home Phone Number

Work Phone Number

8. Injury & Hospital Details

Please note that a specific medical certificate filled out by an appropriately qualified medical specialist will need to be submitted to the Lifetime Support Authority as a part of this Application

An LSA medical certificate proforma is attached to this form or can be found at: www.lifetimesupport.sa.gov.au

What are the injured person's injuries as a result of the motor vehicle accident subject to this application that may make them eligible for the Scheme?

Brain Injury	Spinal Cord Injury	Amputations
Burns	Permanent Blindness	

Does the injured person (applicant) have any other injuries that occurred in the same motor vehicle accident? Please outline.

Does the injured person (applicant) have any pre-existing medical conditions or injuries that are not related to the motor vehicle accident subject to this application? Please outline.

Was the injured person admitted to hospital?	Where?	When?
Yes No		

How was the injured person (applicant) transported to the hospital?

Ambulance	Medstar	RFDS	Private Vehicle
Other			

Has the injured person attended any other health or rehabilitation facilities?	Where?	When?
Yes No		

Has the injured person (applicant) been discharged? What is their discharge destination? Date of discharge?

9. Consent Authorisation - Injured person, or person with lawful authority on their behalf.

Please read the document carefully before signing. **The person who signs this form must be over 18.**

The Lifetime Support Authority may need to speak with and obtain information and/or documents from a number of different sources in order to assess eligibility and, if eligible, to determine the necessary and reasonable treatment, care and support required by the injured person. The persons and/or agencies that the Lifetime Support Authority may need to speak with and obtain documents and/or information from include:

- any doctor, ambulance service, hospital or other service provider;
- health practitioners;
- departments, agencies or instrumentalities of the Commonwealth, the State or another State, administering laws about health.

Where the applicant has impaired decision making capacity, consent can be given on behalf of the injured person by a 'person responsible'. A person responsible is a guardian, a relative or spouse with a close and continuing relationship with the applicant, or an adult friend with a close and continuing relationship with the applicant.

I declare that, to the best of my knowledge, the information given in this Application Form is true and correct in every respect and I understand that the information will be used to assess eligibility for the Lifetime Support Scheme.

I authorise the Lifetime Support Authority to speak with and obtain information and/or documents from any of the persons and/or agencies listed above. I understand that the information obtained may include general, personal and medical information.

I am signing this application and consent as:

- Injured person (the applicant)
- Parent
- Legal Guardian of injured person
- 'Person Responsible' in accordance with the *Consent to Medical Treatment and Palliative Care Act 1995*
- Substitute Decision Maker in accordance with the *Advance Care Directives Act 2013*

Injured person's first name(s)

Injured person's surname / family name

Signature of injured person or Person Responsible

Date

Name of the person signing on behalf of the injured person (if applicable)

Date

Relationship to the injured person if signing on his/her behalf (if applicable) (eg. parent, guardian, etc)

10. Insurer information Declaration (if insurer is completing this application)

Please read the document carefully before signing.

The Lifetime Support Authority needs the information contained in this Application Form to be true and correct.

Please ensure that you have included all documentation required so that the eligibility criteria have been met. The eligibility criteria are:

An application to become a participant in the Scheme is made by, or on behalf of the eligible person, or by the insurer. The application must demonstrate that:

- the person sustained a bodily injury; and
- the injury was caused by or arose out of the use of a motor vehicle; and
- the relevant motor vehicle accident occurred in South Australia; and
- the injury meets the criteria set out in the Lifetime Support Scheme Rules.

I declare that, to the best of my knowledge, the information given in this Application Form is true and correct in every respect.

Signature

Date

Name of the insurer

Name of the person signing on behalf of the insurer

Position of the person signing on behalf of the insurer

Postal address of the insurer

Contact phone number of the insurer

Injured person's first name(s)

Injured person's surname / family name

LSA USE ONLY

11. Checklist

Accident reported to police?

Proof of identity attached (original sighted by LSA Service Planner or certified copy of a birth certificate, passport or drivers license)?

Consent Authorisation/Information Declaration completed?

LSA Medical Certificate attached?

SUBMIT FORM

Lifetime
SUPPORT

Lifetime Support Authority
1300 880 849

Ground Floor, Wakefield House
30 Wakefield Street, Adelaide SA 5000

PO Box 1218, Adelaide SA 5000
Email: lifetime.support@sa.gov.au

www.lifetimesupport.sa.gov.au



Government of
South Australia

OR

PTA is not available but the person has a significant brain imaging abnormality

AND

Is there at least one Functional Independence Measure (FIM) item scored 5 or less as a result of the brain injury (or for a child a WeeFIM item scored 2 or less than the age norm as a result of the brain injury)?

FIM attached?

Yes

Yes

No

No

Do not have access to FIM accredited assessor and require FIM assessment by LSA

Less than 3 years old (This must be completed by a Paediatric Rehabilitation Physician/Specialist)

The child will likely have permanent impairment resulting in a significant adverse impact on their normal development

Please provide reasoning as to how you formed your opinion:

Spinal cord injury

Permanent sensory / motor deficit / bladder dysfunction / bowel dysfunction

Neurological (SCI) level	ASIA impairment scale (Please supply ASIA scoresheet)	ISAFSCI scores
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Amputations

1) Brachial plexus avulsion or rupture equivalent to a single amputation	Left	Right
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2) Single

Single forequarter amputation (complete amputation of humerus, scapula and clavicle)	Left	Right
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OR

Single amputation of the lower limb through or above 65% of the femur	Left	Right
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3) Multiple Amputations – there is more than one of the following amputations of the upper/and/or lower limbs

Please select at least two from below:

At or above 50% of the tibia (lower limb)	Left	Right
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At or above the first metacarpophalangeal joint of the thumb and index finger of the same hand	Left	Right
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Burns**Aged 16 and under:**

The child has full thickness burns to at least 30% of the body, or full thickness burns to the hands, face or genital area, or permanent inhalation burns causing long-term significant respiratory impairment.

Aged Over 16:

Full thickness burns to at least 40% of the body, or full thickness burns to the hands, face or genital area, or permanent inhalation burns causing long term significant respiratory impairment.

AND

Is there at least one Functional Independence Measure (FIM) item scored 5 or less as a result of the burn injury (or for a child a WeeFIM item scored 2 or less than the age norm as a result of the burn injury)?

FIM attached?

Yes

Yes

No

No

Do not have access to FIM accredited assessor and require FIM assessment by LSA

Note: A FIM score for burns injury is only required if this certificate is supporting an application for lifetime participation in the Scheme

Permanent Blindness

The injured person is legally blind

Visual acuity on the Snellen Scale after correction by suitable lenses is less than 6/60 in both eyes; or

Field of vision 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

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

Please sign the declaration overleaf

Declaration

I declare that I am a medical specialist experienced in the injury type described above, I have examined the injured person and to the best of my knowledge the above injuries are consistent with the motor vehicle accident as reported to me, or are consistent with the trauma that may arise out of a motor vehicle accident.

Medical specialist's name

Qualifications

Contact phone number

Hospital/Facility

Signature

Date

Additional Information

Is there any other information that is relevant?

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