Australian Government
Department of Health and Aged Care

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Hearing Services Program

Request for Revalidated Service

Part 1 – Applicant Information

1. Client Details

Please provide details.

First or Given Name (Required)

Name

Surname/Family Name (Required)

Surname

Date of Birth (Required)

Day *Month* *Year*

01 - 01 - 1952

Voucher Number (e.g. 165999917J-16042020) (Required)

165999917J-16042020

► More Information about Voucher Number

Date of expiry for client's current voucher (Required)

Day (dd) *Month (mm)* *Year (yyyy)*

10 - 10 - 2025

Note: If the request for Revalidated Service is within 3 months of the voucher expiry date, please reconsider the request. Determine if the client's circumstances in hearing or health has changed significantly or if the reason to reassess or refit is **urgent** e.g. risk of harm/danger if this service is not provided before their current voucher expires.

2. Provider Details

Please provide details of the provider below.

Provider Trading Name (Required)

Trading Name

Provider Number (Required)

%%%

Provider Email (The outcome will be sent to the address provided here).
(Required)

example@emailaddress.com

► More Information about Provider Email

Qualified Practitioner Name (Required)

QP Name

Qualified Practitioner Number (Required)

1234567X

Telephone Number (Required)

(02) 1234 5678

Part 2 – Reason for Request for a Revalidated Service

Required Information for Reason A

Reason A should be selected if the client's hearing thresholds have permanently deteriorated by **15dB or more** at two or more frequencies between 500Hz and 4000Hz in at least one ear. The following information is required for Reason A and should be included on the request form.

- Results of the previous audiogram
- Results of a recent audiogram/screening test
- Tympanometry results if bone conduction testing was not completed.

▶ Successful Submission Example - Reason A

Required Information for Reason B

Reason B should be selected if your client is eligible for refitting under the current ECR guidelines but a fitting has already been claimed on their current voucher. The following information is required for Reason B and should be detailed on the request form.

- Claim item number to be claimed
- ECR under which you are refitting
- Clinical justification for the refit
- Evidence to support the refit

► Successful Submission Example for Reason B ECR 1

► Successful Submission Example for Reason B ECR 2

► Successful Submission Example for Reason B ECR 3

► Successful Submission Example for Reason B ECR 4

► Successful Submission Example for Reason B ECR 5

Please select the Reason for Request for a Revalidated Service

(Required)

- ○ Reason A – client requires a reassessment (800/810)
- ○ Reason B – ECR 1
- ◉ Reason B – ECR 2
- ○ Reason B – ECR 3
- ○ Reason B – ECR 4
- ○ Reason B – ECR 5

Please select the claim item number to be claimed

Claim item number (Required)

830 ⌄

Part 3 – Supporting Evidence for Reason B ECR 2

The current hearing device(s) is/are unsuitable because the client can no longer use their device(s) due to a significant deterioration in health, dexterity, cognitive ability or speech discrimination since the last fitting. Please note that lifestyle changes such as the client wearing spectacles or becoming a carer are not valid reasons for a revalidated service.

► Successful Submission Example for Reason B ECR 2

1. Audiogram

Please provide the client's most recent 3 Frequency Average Hearing Loss (3FAHL).

Left 3FAHL (Required)

48

Right 3FAHL (Required)

45

2. Details of the deterioration

Please provide **details on the deterioration in client health, dexterity cognitive ability or speech discrimination** since the last fitting.

What type of deterioration has occurred? (Please select all that apply)

- [x] Health
- [ ] Dexterity
- [x] Cognitive Ability

For ECR 2 requests where deterioration in speech discrimination is the only deterioration nominated, please leave tick boxes blank and include details of the deterioration in your supporting statements.

Date of last fitting (Required)

Day (dd)	Month (mm)	Year (yyyy)
23	10	2018

Date the deterioration was reported (Required)

Day (dd)	Month (mm)	Year (yyyy)
1	07	2022

Describe the deterioration in health, dexterity, cognitive ability or speech discrimination (Required)

Client's health has deteriorated recently, and led to a diagnosis with dementia. Client described issues with device management, she forgets to change programs in different settings, and to change batteries etc. She is finding this very frustrating, tremors and shakes add to her frustration

Note: Changes in client's life circumstances, including the use of spectacles or becoming a carer, are not valid reasons for refitting under ECR 2, which stipulates a deterioration in **client health, dexterity, cognitive ability or speech discrimination.**

Note: If the reason for this application is due to a deterioration in **dexterity**, please include the necessary evidence to demonstrate why a remote control for the client's current device(s) is/are not considered appropriate in this instance.

☑ I declare that the changes to the client's life circumstances do not include the use of spectacles or becoming a carer. (Required)

Regarding their **current** device(s) (at the follow-up appointment)

1. Was the original fitting deemed successful?

(Required)

- (●) Yes
- ( ) No

2. Were the client's hearing goals met?

(Required)

- (●) Yes
- ( ) No

3. Was the client able to manage the device(s) independently?

(Required)

- (●) Yes
- ( ) No

Note: If the answers to the above are 'No', the program will investigate the original fitting to ensure this has met program requirements.

3. Details on the current device(s) or fitting

Why are the current device(s) no longer suitable? (Required)

The current ITC are no longer suitable because the client is unable to correctly insert devices despite efforts to train the client on device management. In addition, she is unable to change the batteries or feel the volume and program control buttons. This has caused frustration and the client has now lost motivation to wear the devices.

Note: Compliance monitoring has shown that devices are being fitted without taking into account the suitability of the device or exploring other management options. Please ensure the client's current device is checked for suitability before considering a refitting.

Did the client voice any concerns about the device(s) and/or fitting?

(Required)

- ○ Yes
- ◉ No

If yes, please describe below if their concerns were addressed and resolved

No, the devices were successfully fitted in January 2016. The client was happy with the devices and there was no indication the client was having management difficulties.

4. Details on how the issues were addressed

Please provide details on the **attempts to resolve issues with the current device(s).**

Is there a family member or carer (e.g. nursing home staff) able to assist the client with their current device management? (if yes, this application should not be submitted)

(Required)

- ○ Yes
- ◉ No

Has a remote control been considered to assist the client with the current device management? (if no, please consider if supplying a remote would be more appropriate)

(Required)

- ◉ Yes
- ○ No

► More Information on Remote Control

Describe what has been tried with the current device(s) and/or why they cannot be modified. (Required)

The client has no local family members that can help with managing the devices on a daily basis. The client lives independently in her own home and has no carer to assist them. A remote control was trialled but the client became confused and frustrated when they were shown how to use the remote, they showed no motivation in using it.

5. Details on proposed solution

Please provide details on the proposed solution.

Fully Subsidised Schedule

Partially Subsidised Schedule

Note: If the client has a monaural fitting configuration or a non-scheduled device(s), please enter **N/A** in the relevant fields below.

Left Ear Device Code (Required)

B321AID

Right Ear Device Code (Required)

B321AID

► More Information on Device Codes

Describe what new device(s) are proposed and how will they address the current issue (Required)

We are proposing to refit the client with BTE devices and a 3/4 shell mould. The client trialled a pair of BTE devices and was able to independently insert the devices into her ear (after some practice). To avoid confusion with volume and program changes, we will ensure the devices are set to automatic (i.e. no volume or program controls).

6. Doctor's letter

Please note: This letter is not required where speech discrimination is the only deterioration nominated.

- [x] I declare that a doctor's letter has been obtained that clearly states the date and condition/deterioration in health, dexterity and/or cognitive ability the client experiences.

Name of Medical Practitioner

Dr X

Name of the medical clinic or hospital

Vaudeville General Practice

Part 4 – Acknowledgement and Completion of Application

By ticking the boxes below,

- ☑ I declare a copy of the Request for Revalidated Service form along with supporting relevant evidence, including the outcome email will be retained on the client record. (Required)
- ☑ I declare that the client has met the MHLT exemption criteria if the client's 3FAHLs are less than 23dB. (Required)
- ☑ I certify that the client's circumstances in hearing or health have changed significantly, and the reason for requesting a revalidated service is urgent, e.g. risk of harm/danger if this service is not provided before their current voucher expires. (Required)
- ☑ I declare that the request for a Revalidated Service has been discussed with the client or their Power of Attorney (POA). Consent has been obtained from the client, or if the client is incapable, consent has been obtained from the client's POA or equivalent. (Required)
- ☑ I understand the Request for Revalidated Service Form and supporting evidence are subject to compliance monitoring, including audit. (Required)
- ☑ I declare the information submitted is true and correct and understand that providing false and misleading information is a criminal offence. (Required)

Completion of Application

Thank you for completing your application to request a Revalidated Service under the Australian Government Hearing Services Program.

Please note, once you submit your application you will not be able to edit or make changes to this online application form. Make sure that you have reviewed your application before submission. The Hearing Services Voucher Operations team will inform you if additional information is required once an initial review of your application has been conducted.

Almost done...

You are about to submit your response. By clicking 'Submit Response' you give us permission to analyse and include your response in our results. After you click Submit, you will no longer be able to go back and change any of your answers.

If you provide an email address you will be sent a receipt and a link to a PDF copy of your response.

Email address

example@emailaddress.com

Your response has been submitted

Your response ID is XXXX-XXXX-XXXX-X. Please have this ID available if you need to contact us about your response.

A receipt for your response has been emailed to you from the address **health.gov.au@mail1.citizenspace.com** with the subject "**Consultation response received - Response ID: XXXX-XXXX-XXXX-X**". If it doesn't appear in your inbox within a couple of minutes, please check your "spam" or "junk" folder.

Thank you for your submission.

Please allow 10 days for an outcome to your Request for Revalidated Service application. For enquiries regarding any application please contact the Program by email Hearing@Health.gov.au, include your response ID number.

Kind Regards,

Voucher Operations Section

Hearing Services Program