Continence Product Subsidy Scheme (CPSS) Child Application Form

Please email the completed form to **DOH.CPSS@health.wa.gov.au** with a copy of the NDIS Access decision letter.

Continence Advisor Details

Name		Phone	
Organisation		Email	

Parent / Guardian Details

First Name		Phone	
Last Name		Email	

Child Details

First Name		Referral Date	
Last Name		Date of Birth	
Delivery Address		Age	
		Gender	☐ Male ☐ Female ☐ Unspecified
Postcode		HealthCare Card No	
Permanent resident of WA	☐ Yes ☐ No	NDIS access denied	☐ Yes ☐ No
Permanent resident at home	☐ Yes ☐ No		

Receive carer's allowance or payment for the child from Centrelink	☐ Yes ☐ No
Has a continence condition from disability / medical condition	☐ Yes ☐ No
Child currently in receipt of Commonwealth/ CAPS funding	☐ Yes ☐ No

Primary Disability

Acquired Brain Injury
- ☐ Stroke
- ☐ Brain Tumour
- ☐ Traumatic Brain Injury

Neurodevelopmental
- ☐ ADHD
- ☐ Autism
- ☐ Specific Learning
- ☐ Intellectual

Neurological
- ☐ Epilepsy
- ☐ Muscular Dystrophy
- ☐ Spinal Cord Injury
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Functional Neurological Disorder

Physical
- ☐ Amputation
- ☐ Deaf/Blind
- ☐ Visual Impairment
- ☐ Speech Impairment
- ☐ Mental Health Condition

Other (specify) _____

Other Significant Disabilities

Acquired Brain Injury
- ☐ Stroke
- ☐ Brain Tumour
- ☐ Traumatic Brain Injury

Neurodevelopmental
- ☐ ADHD
- ☐ Autism
- ☐ Specific Learning
- ☐ Intellectual

Neurological
- ☐ Epilepsy
- ☐ Muscular Dystrophy
- ☐ Spinal Cord Injury
- ☐ Cerebral Palsy
- ☐ Spina Bifida
- ☐ Functional Neurological Disorder

Physical
- ☐ Amputation
- ☐ Deaf/Blind
- ☐ Visual Impairment
- ☐ Speech Impairment
- ☐ Mental Health Condition

Other (specify) _____

Describe the Diagnosis / Disability / Impact of Incontinence

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Product Recommendations

Product Code	Product Description	Quantity

Please note: if no order is being placed at time of assessment, enter zero in the "Quantity Required" column..