

# Application for Life Support Identification

1. Are you registered with the Office of State Revenue for the Life Support Equipment Energy Subsidy Scheme?

- Yes (complete sections 1 and 3)     No (go to question 2 below)

2. Are you a new applicant for Horizon Power's Life Support Identification and are not registered under the Life Support Equipment Energy Subsidy Scheme?

- Yes (please complete all sections)     No (this is a renewal, complete sections 1 and 3)

## Section 1: Applicant Details

Horizon Power Account Number             Title (Mr/Mrs/Ms)

First Name

Surname

Name (as it appears on your electricity bill)

Date of Birth

Phone (work)

Phone (home)

Mobile No.

Home address (where life support equipment is being used)

Suburb  Postcode

Postal Address (if different from home address)

Suburb  Postcode

Email Address

## Patient Details

Is the home-based life support equipment for your use?     Yes     No (If no, please complete Dependant Details below)

## Dependant Details

Title (Mr/Mrs/Ms)  First Name

Surname

Date of Birth

Relationship to you (mother, child etc)

## Section 2: Practitioner Details (Only new applicants need to complete this section)

A Specialist, General Practitioner or nursing professional must complete all details in this section.

Practitioner Name

Hospital (where applicable)

Position in hospital (where applicable)

Provider No.

Stamp (if available)

### Life Support Equipment List

Please tick item(s) prescribed

- |  |  |
|--|--|
| <input type="checkbox"/> Ventilator (VPAP or BPAP only)                | <input type="checkbox"/> Apnoea Monitor (Child only)*                          |
| <input type="checkbox"/> Oxygen Concentrator Standard Capacity (Adult) | <input type="checkbox"/> Heart Pump  |
| <input type="checkbox"/> Oxygen Concentrator High Capacity (Adult)     | <input type="checkbox"/> Nebuliser (Child only - used everyday for 1-2 hours)* |
| <input type="checkbox"/> Oxygen Concentrator (Child Only)*             | <input type="checkbox"/> Other (please specify) _____                          |
| <input type="checkbox"/> Feeding Pump                                  | <small>* A child = under the age of 16 years</small>                           |
| <input type="checkbox"/> Suction Pump                                  | <small>Does not include items used as back-up equipment</small>                |

### Sign and Return

I (full name of medical Practitioner)

certify that I have prescribed the following life support equipment for:

Name (of patient on life support equipment at home)

Signature (of Medical Practitioner)  Date

Phone

### Section 3: Applicant Authorisation and Declaration

- I will notify Horizon power in writing of any changes that affect either the validity of this application or my entitlement to the Life Support account Identification.
- I understand that this application is only valid for 12 months and will need to be renewed after this time.
- All particulars on this form are, to the best of my knowledge and belief, true and accurate.

Signature (of applicant or carer)  Date

#### Return the complete application form to Horizon Power

By mail GPO Box P1145, Perth WA 6844  
 By facsimile 1800 420 998  
 For further information  
 Website [www.horizonpower.com.au](http://www.horizonpower.com.au)  
 Email [enquiries@horizonpower-reply.com.au](mailto:enquiries@horizonpower-reply.com.au)  
 Telephone 1800 267 926  
 Hours 8.00am to 5.00pm, Monday to Friday

#### For more information regarding the Life Support Equipment Electricity Subsidy

By mail Office of State Revenue, GPO Box T1600, Perth WA 6845  
 Website [www.osr.wa.gov.au](http://www.osr.wa.gov.au)  
 Email [lifesupport@dtf.wa.gov.au](mailto:lifesupport@dtf.wa.gov.au)  
 Telephone (08) 9262 1373 Facsimile (08) 9262 1597  
 Hours 8.00am to 5.00pm, Monday to Friday

### Office Use Only

NMI

Meter No.