INCONTINENT PAD SCHEME (IPS) APPLICATION FORM

Parent/Guardian Details

Title:	Given Name:	Family Name:	
Postal Address:		State:	Post Code:
Telephone: ( )	Email:		

Child Details

Given Name:	Family Name:		
Date of Birth: / / Age: Months:	Gender: ☐ Male ☐ Female	Weight: Kg	
Delivery Address:		Post Code:	
* Health Care Card Carer Allowance Number:			
Permanent resident of Western Australia? ☐ Yes ☐ No	Permanent resident at home ☐ Yes ☐ No		
Has a continence condition from a disability ☐ Yes ☐ No	Is between 3-16 years old ☐ Yes ☐ No		
Do you receive a carer's allowance or carer's payment for the child from Centrelink ☐ Yes ☐ No			
Describe the diagnosis/disability:			
Is the child currently in receipt of Commonwealth/CAPS funding? ☐ Yes ☐ No			

Product Details

Code	Description	Size	Day/Night
Estimated Annual Usage (units):	Initial Qty Required (cartons):		

Code	Description	Size	Day/Night
Estimated Annual Usage (units):	Initial Qty Required (cartons):		

Code	Description	Size	Day/Night
Estimated Annual Usage (units):	Initial Qty Required (cartons):		

Parent/Guardian Signature: _____ **Date:** _____

*** A photocopy of a Health Care Card clearly showing the Carer Allowance Number must be attached with this Application Form**

Please send the complete Application Form to Independence Australia: Replied Paid 9910 Melbourne VIC 8060
Fax: 1300 788 811 or Email: customerservice@independenceaustralia.com