

## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female Weight: Kg
Delivery Address: Post Code:	
* Health Care Card Carer Allowance Number:	
Permanent resident of Western Australia? <input type="checkbox"/> Yes <input type="checkbox"/> No	Permanent resident at home <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a continence condition from a disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Is between 3-16 years old <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive a carer's allowance or carer's payment for the child from Centrelink <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe the diagnosis/disability:	
Is the child currently in receipt of Commonwealth/CAPS funding? <input type="checkbox"/> Yes <input type="checkbox"/> No	

### Product Details

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

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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