Notice and Consent for Disability Support for Older Australians (DSOA) providers to share your information

We, the Department of Health (**the Department**), run the DSOA Program on behalf of the Commonwealth Government. Your personal information is needed to arrange and manage your participation.

By completing and signing this form, you can agree to:

* the Department collecting your personal information to check if you can take part in the DSOA Program; and
* the Department and/or your DSOA provider[[1]](#footnote-1) sharing your personal information with other people who may need it to arrange your participation in the DSOA Program.

**PRIVACY NOTICE**

This notice deals with how the Department will handle your information. Other organisations will tell you separately how they will handle your information.

Your personal information is protected by law, including the *Privacy Act 1988* (**Privacy Act**) and the Australian Privacy Principles (**APPs**).

We collect, use and disclose your personal information to check if you can take part in the DSOA Program. As part of our checks, we will see if you are receiving any aged care services.

If you consent to participating in the DSOA program, we will collect, use and disclose your personal information to organise your participation. If you have more than one provider, we will share information about your individual support package with each of your providers.

**What personal information is shared?**

You decide what information you share, based on the boxes you select in this form. You can agree to sharing information about yourself, your disability and your package.

**What happens if I don’t share my personal information?**

You do not have to share your personal information. If you have more than one provider, we cannot share information each provider needs to deliver services to you, unless you give use your permission to do so. If we cannot share information, you may not receive services that you are entitled to receive.

If you want to stop sharing your personal information, you can ask contacting us via CommonwealthDSOA@health.gov.au

**Who will we share your information with?**

To arrange and manage your participation in the program, we may share personal information we receive about you with:

* another provider if you receive services from more than one provider
* a subcontractor engaged to assist in delivering services
* an independent assessor
* your authorised representative
* other third parties with your consent.

**How will my information be secured?**

Under the Privacy Act, we are required to take reasonable steps to protect your personal information, including by securely storing your personal information. Any personal information you provide to us is held securely. More information is available in our privacy policy.

**Our privacy policy**

Our privacy policy contains further information about how we handle your personal information including how you can access and correct the personal information we hold about you or make a privacy complaint. You can read our privacy policy at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/privacy-policy>.

You can contact the Department by telephone on (02) 6289 1555 or freecall 1800 020 103 or by using the online enquiries form at [www.health.gov.au](http://www.health.gov.au).

# How do I return this form to the Department?

* **Email:** CommonwealthDSOA@Health.gov.au
* **Mail:** Disability Support for Older Australians, GPO Box 9848, Canberra ACT 2601

## If you need assistance completing this form please advise your provider, who will arrange assistance for you.

##

## Part A: DSOA client details

**Note:** If you are **not** the client, and are the authorised representative (see Part B), please enter the client’s details in this section.

| Full name |  |
| --- | --- |
| Date of birth (DD/MM/YYYY) |  |
| DSOA client ID |  |
| Phone number (best contact) |  |
| Email address |  |
| Address (including post code) |  |

Part B: Authorised representative details

Please provide your details if you are completing this form on behalf of a DSOA client as their authorised representative. You may be asked to provide proof of identity.

| Representative full name |  |
| --- | --- |
| Organisation (if applicable) |  |
| Phone number (best contact) |  |
| Email address |  |
| Address |  |

**Please mark the relevant box below to indicate your relationship to the client**

|  |  |
| --- | --- |
| [ ]  Nominated carer/family member | Ensure client completes Part B1 |
| [ ]  Advocate | Ensure client completes Part B1 |
| [ ]  Legally appointed decision maker | You may be asked to provide evidence of appointment |

Part B1: Appointment of Authorised representative

If you would like to appoint an authorised representative to act on your behalf in relation to your participation in the DSOA Program, please indicate your consent below.

[ ]  I consent to and authorise the organisation or individual identified in Part B to act on my behalf in all matters relating to my participation in the DSOA program.

## Part C: Agreement to share information with the Department, providers and independent assessors

Please indicate your consent by marking the boxes below. Your consent is needed to confirm your eligibility to participate in the program, and to facilitate your participation. Detailed information about how your information will be handled is set out above in the Privacy Notice.

[ ]  I consent to the Department collecting the following information about me (or the client I am representing) from my provider/s, their subcontractors, and independent assessors:

|  |  |
| --- | --- |
| * name
 | * postcode
 |
| * DSOA client ID
 | * gender
 |
| * date of birth
 | * Individual Support Package (ISP) information.
 |

[ ]  I consent to the Department sharing the following information about me (or the client I am representing) to my providers (listed below), their subcontractors, and independent assessors:

|  |  |
| --- | --- |
| * name
 | * postcode
 |
| * DSOA client ID
 | * Individual Support Package (ISP) information.
 |
| * date of birth
 | * Independent Assessment Reports (IARs)
 |

[ ]  I consent to my provider sharing the following information about me (or the client I am representing) to my providers (listed below), their subcontractors, and to the independent assessors:

|  |  |
| --- | --- |
| * name
 | * IARs
 |
| * DSOA client ID
 | * behaviour, medical and therapy reports
 |
| * date of birth
 | * authorised representative details
 |
| * postcode
 | * contact information (phone, email, address)
 |
| * ISP information
 |  |

| Kyeema contact  |  |
| --- | --- |
| Organisation name | Kyeema Support Services Inc. |

## Part D: Your declaration

* You can direct someone aged 18 and over to sign (your ‘delegate’) in the presence of a witness.
* If you need assistance to complete and sign this form, please advise your provider, who will arrange assistance for you.

**If you direct a delegate to sign on your behalf**, your delegate and witness needs to complete [Part E](#_Part_E:_Your). Otherwise, please sign, below.

**By signing this consent form (please mark each box below) I confirm:**

[ ]  I have read and understand the matters set out in the Privacy Notice and this form, and understand I can obtain further information about how the Department handles my personal information from the Privacy Notice or Privacy Policy on the Department website.

[ ]  I consent to the Department of Health and my providers giving information about me to the providers listed at [Part C](#_Part_C:_Third) on this form and any independent assessor.

**An authorised representative can make this declaration on behalf of a client.**

| Signature |  |
| --- | --- |
| Name |  |
| Date (DD/MM/YYY) |  |

## Part E: Your delegate’s declaration

**Please note:** This section is **only** to be completed if the client does not want to nominate an authorised representative, but is unable to sign this form in [Part D](#_Part_D:_Your). If this is the case, you may nominate a ’delegate’ to sign for you. The delegate must be aged 18 and over and must sign in the presence of a witness.

| Signature of client’s delegate |  |
| --- | --- |
| Name of client’s delegate |  |
| Signature of witness |  |
| Name of witness |  |
| Date (DD/MM/YYY) |  |

**Witness certification (please mark each box below):**

[ ]  I certify this document was signed by the delegate in the presence of the person providing consent

[ ]  I certify, to the best of my knowledge, that the person giving consent read (or had the information read or explained to them) and understood the matters set out in the Notice and Consent form.

[ ]  I certify that, to the best of my knowledge, the person providing consent was capable of providing consent and did so voluntarily.

1. Providers is this instance includes the following, DSOA service provider, subcontractors, the Community Grants Hub, Department of Health, Centre for Disability Services. [↑](#footnote-ref-1)