



Mental Health Nurse Incentive Program application

Important information

The information provided in this application form will be used to assess your organisation's eligibility to receive funding under the Mental Health Nurse Incentive Program. This program provides funding to enable eligible private psychiatry practices, general practices and other appropriate organisations to engage specialist mental health nurses to provide support services to patients with a severe mental health disorder. For further information refer to the *Mental Health Nurse Incentive Program Guidelines* (Program Guidelines).

Assistance

If you would like more information about the Mental Health Nurse Incentive Program:

- call Medicare Australia on **1800 222 032** (call charges may apply) between (8.30 am - 5:00 pm Australian Central Standard Time).
- email: **mhnip@medicareaustralia.gov.au**
- online: **www.medicareaustralia.gov.au** then go to **For health professionals > Incentives & Allowances**

All forms related to the Mental Health Nurse Incentive Program are available from our website.

Lodgement details

Send the completed and signed form to:

Mental Health Nurse Incentive Program
GPO Box 2572
Adelaide SA 5001

or fax to: **1300 581 573**

Completed application forms cannot be lodged electronically and must be mailed or faxed to Medicare Australia.

Ensure you keep a copy for your records.

Tick where applicable

Change of details

Changes to eligible organisation arrangements may have an affect on eligibility and payments for the Mental Health Nurse Incentive Program. Medicare Australia must be advised within 14 calendar days of any relevant changes to arrangements, such as banking details or address details.

All correspondence will be sent to the nominated contact at the postal address provided in this application. The nominated contact person is responsible for notifying Medicare Australia in writing of any changes to eligible organisation arrangements. Failure to do so could affect payments.

False or misleading information

Medicare Australia has powers under the *Medicare Australia Act 1973* to verify the information provided in this application form.

Penalties exist under the *Medicare Australia Act 1973* and the *Commonwealth Crimes Act 1914* for giving false and misleading information. Medicare Australia will take steps to recover any resulting overpayments if:

- inaccurate information is provided in the application form
- or**
- the applicant fails to notify Medicare Australia (at the address shown at the beginning of this application form), of any relevant changes in arrangements.

Medicare Australia may suspend payments and/or recover any overpayments that eventuate as a result of the provision of incomplete or inaccurate information.

1 Organisation type

- General practice
- Private psychiatry practice
- Aboriginal and Torres Strait Islander Primary Health Care Service funded through the Australian Government by OATSIH
- Division of General Practice

2 Organisation name (eg Smithtown Medical Practice)

Authorised contact

These people must be the proprietor or the authorised representative of the organisation who can advise Medicare Australia of changes to arrangements. All written correspondence will be addressed to the primary contact.

Primary contact

3 Dr Mr Mrs Miss Ms Other

Family name

First given name

4 Work phone number

Mobile phone number

Fax number

Email

Secondary contact

5 Dr Mr Mrs Miss Ms Other

Family name

First given name

6 Work phone number

Mobile phone number

Fax number

Email

7 Address details for main organisation location

| | | |
|----------------------|----------------------|----------------------|
| Level | Suite | Floor |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Building

Location address

 Postcode

8 Postal address of the organisation (For all correspondence)

- Same as address above

| | | |
|----------------------|----------------------|----------------------|
| Level | Suite | Floor |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Building

Location address

 Postcode

9 Australian Business Number (ABN)

 - - -

Bank account details

Note: bank account details are required as payments are made through electronic funds transfer only.

10 Name of bank, building society or credit union

Branch where your account is held

Branch number (BSB)

 -

Account number (this may not be your card number)

Account held in the name(s) of

Declaration

11 I declare that:

- the information provided in this form is true and correct and that the organisation will be able to provide evidence in support of the statement
- I am aware of the requirements for eligibility set out in Section 9 of the Program Guidelines and acknowledge that Medicare Australia may require evidence that I satisfy these requirements
- I will inform Medicare Australia in writing within 14 calendar days (at the address shown on this application form), if there is any change in arrangements that will affect eligibility for any payments, under the Mental Health Nurses Incentive Program.

I understand that Medicare Australia may:

- access information regarding services provided by the eligible organisation to calculate payments
- provide reports regarding information on this application form and services provided by the eligible organisation to the primary contact on this form
- provide information (which may include identifying information) relating to this application form to the Department of Health and Ageing for statistical, research and policy development purposes
- suspend, cease or recover the eligible organisation's payments where requirements of the Program Guidelines are not met, or if evidence of compliance with the Program Guidelines cannot be provided and continuing eligibility for the payments may be affected.

Name of organisation primary contact person

Organisation primary contact person's signature

Date

Witness name

Witness signature

Date

Privacy

The information provided in this form will be used to determine eligibility for the Mental Health Nurse Incentive Program. The collection of this information is authorised by the *Medicare Australia Act 1973*. Information provided may be disclosed to the Department of Health and Ageing for the purposes of administering this program or as authorised or required by law. The banking details provided on this form will be retained on Medicare Australia records and will only be disclosed to the relevant financial institutions to facilitate electronic payments or as authorised or required by law.

Checklist

- Has a primary and secondary contact person been nominated? (refer to question 3 to 6)
- Are the postal details correct? (refer to question 8)
- Are the payment details correct? (refer to question 10)
- Has the declaration been completed (including the date and witness signature) and signed by the authorised person? (refer to question 11)