Instructions

Australian Government
Department of Health and Aged Care

Hearing Services Program

Voucher scheme – Request for Reconsideration of Reviewable Decision

Purpose

Use this form to ask the Hearing Services Program to reconsider (conduct an internal review of) a decision it has made under the *Hearing Services Administration Act 1997*. For information on decisions able to be reconsidered, see the **Complaints Policy** on our website **www.health.gov.au/hear**

What we will do

Your application will be reviewed by an officer of the Department of Health and Aged Care who did not make the original decision. They will

- review the decision, taking into account any evidence you have provided
- uphold, vary or revoke the original decision and
- advise you of the outcome of the review in writing.

Privacy Notice

Any personal information about you collected by the department for the program will be managed in accordance with the *Privacy Act 1988*.

If information is provided via our website, additional privacy and security measures apply. More information on these measures can be found at the Privacy page of the department's website.

When you provide information to the department for the purposes of the program, please be aware that the department may disclose this information to other government agencies including: Centrelink, Medicare, the Department of Veterans' Affairs, the Department of Defence or the National Disability Insurance Agency.

Your information will only be used for the following purposes

- checking your eligibility for the program
- investigation of your request
- enabling the effective administration and accountability of the program, and
- analysis for the purpose of improving service delivery and policy.

When to submit

You must request a review within 28 days of the date of the decision. You may ask for this time period to be extended and explain why you did not submit this form within that time.

Instructions

- Complete all applicable fields in the form
- Make sure you have explained in **Section C** why the original decision is incorrect and ensure that you have signed the declaration at **Section D**
- Attach any additional information to this form and
- Send the form and all supporting information to

email **hearing@health.gov.au**, ensuring that the word 'Reconsideration' is included in the message subject line.

or

mail Department of Health and Aged Care
Hearing Services Program
GPO Box 9848 Mail Drop Point 113
Canberra ACT 2601

Instructions Save as Print Clear

Section A – Applicant details

* Indicates mandatory information

Title * **Given name**

* **Family name**

* **Postal address**

State Postcode

Contact phone number

( )

Email

Do you want to be contacted by:

☐ Email ☐ Phone ☐ Post

Eligibility number, if for client
(CRN, DVA/PMKey, ADF, JSID or NDIS number)

If you are the client

Date of birth (DD/MM/YYYY)

/ /

If you are applying on behalf of a client

Client's full name

Contact phone number

( )

Email

Relationship to client (Guardian, POA)

If you are a service provider or applying on behalf of a service provider

Provider Number Site Id

Trading Name

Section B – Decision for review

* What is the decision you want the program to reconsider, noting that not all decisions are able to be reconsidered?

(See **Complaints Policy** on our website at **www.health.gov.au/hear**)

* What was the date of the decision (DD/MM/YYYY)?

/ /

* Who was the decision maker?

Section C – Reason for reconsideration request

* Explain why you do not agree with the decision or provide details of incorrect information the decision was based on.

Do you have additional supporting evidence not supplied in the original request?

☐ No ☐ Yes (please attach)

Section D – Declaration *

I declare that

- The information I have provided in this form is complete and correct.

I understand that

- Giving false or misleading information is a serious offence.

Applicant's signature

Date (DD/MM/YYYY)

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