

HEALTH MANAGEMENT PROGRAMS PROVIDER APPLICATION

Certain HCF products pay benefits towards Health Management Programs such as Weight Management, Smoking Cessation, Learn to Swim, Childbirth Education etc. Please complete this form if you wish to apply as a provider of one of these programs. If you wish to apply for more than one clinic, complete a separate application for each of your practice or facility. This application must be completed by a person who has authority to contract on behalf of the proprietor/s.

Complete and fax to **02 8296 4758**, alternatively you can email **provider_relations@hcf.com.au** or mail **Ancillary Provider Relations, GPO Box 4242, Sydney NSW 2001**

1 PLEASE SELECT THE TYPE OF PROGRAM FOR WHICH YOU ARE SEEKING PROVIDER RECOGNITION

HCF's minimum requirements are shown below

- Childbirth Education (AHPRA registered Nurse & Midwife - program must take place in a hospital, medical facility or under a shared care agreement with a hospital or community health centre)
- Lactation Consultant (IBCLC and LKANZ)
- Learn to Swim (AUSTSWIM Gold/Silver, Swim Australia or ASSA recognised swim schools/centres only)
- Quit Smoking (Psychologist must have program responsibility)
- Stress Management (Psychologist must have program responsibility)
- Weight Management (Dietician must have program responsibility)

2 PROGRAM PROVIDER AND BUSINESS DETAILS (PLEASE USE CAPITAL LETTERS AND A BLACK PEN)

Title	First name	Surname		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Name of the program you deliver				
<input type="text" value="ROYAL LIFE SAVING'S SWIM AND SURVIVE"/>				
Business name			ABN	
<input type="text"/>			<input type="text"/>	
Parent company name (if you are owned or franchised by a separate business entity)			ABN or ACN	
<input type="text"/>			<input type="text"/>	
Lot number	Suite/unit number	Shop number	Building and floor number/property name (if applicable)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Unit no.	Street no.	Street name		Street type
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>
Suburb		State	Postcode	
<input type="text"/>		<input type="text"/>	<input type="text"/>	
Phone	Fax	Mobile		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Email				
<input type="text" value=""/> @ <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>				
Website (if applicable)				
<input type="text" value="W. W. W ."/>				

3 PHYSICAL ADDRESS WHERE THE PROGRAM IS DELIVERED (IF DIFFERENT TO ABOVE)

Lot number	Suite/unit number	Shop number	Building and floor number/property name (if applicable)		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		
Unit no.	Street no.	Street name		Street type	
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	
Suburb		State	Postcode		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Phone	Fax	Mobile			
<input type="text"/>	<input type="text"/>	<input type="text"/>			
Email					
<input type="text" value=""/> @ <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>					
Website (if applicable)					
<input type="text" value="W. W. W ."/>					

4 TYPE OF FACILITY WHERE YOUR PROGRAM IS DELIVERED

- Private practice in a medical facility
 Private hospital
 Mobile practice
 Private practice
 Public hospital

Other

NAME OF SWIMMING FACILITY WHERE LESSONS ARE CONDUCTED

Do you provide mobile services? No Yes



If yes, please give details

5 DETAILS OF THE HEALTH PROFESSIONALS OR INSTRUCTORS WHO DELIVER THE HEALTH MANAGEMENT PROGRAM

Please attach copies of the board/association or industry body that governs your profession. Please use a separate sheet if necessary and attach copies of relevant certificate/s for each provider that delivers your program.

Full name

Medicare provider number (if applicable)

Qualifications



LIST SWIM TEACHER & FIRST AID QUALIFICATION

Name of the professional association/body that governs profession

ROYAL LIFE SAVING SOCIETY

Full name

Medicare provider number (if applicable)

Qualifications

LIST SWIM TEACHER & FIRST AID QUALIFICATION

Name of the professional association/body that governs profession

ROYAL LIFE SAVING SOCIETY

6 PROGRAM DETAILS

6a. Please describe the program you deliver including content, aims and objectives

SWIM AND SURVIVE - SWIMMING LESSONS FOR WATER SAFETY, EXERCISE AND HEALTH

Course duration

Months

Years

Group sizes (if applicable)

Is the entire program delivered face to

face? Yes No

If no, please give details

6b. For stress management or quit smoking program

Is the entire program delivered face to face?

Yes No

6c. For weight management programs

Is your program designed in consultation with a dietician?

Yes No Please provide evidence of the effectiveness of your program. Include reference studies, research data, cohort size and clinical studies.

Is the Weight Management program a standardised weight management program?

Yes No

If yes, please give details

Does the program provide long term maintenance support?

Yes No

If yes, please give details

7 QUALITY AND SAFETY

To be completed if you deliver a Childbirth Education, Quit Smoking, Stress Management or Weight Management program

7a. Do you have a documented policy and procedure in place should an adverse event occur during the delivery of a program?

Yes No

If yes, please describe or separately attach your policy or procedure

7b. Is your facility and /or program accredited by an independent review body?

Yes No

If yes, please tell us the name of the accrediting body?

If you answered **no** to the above question, please complete the questions below

Please describe how your services are evaluated for quality and safety?

7c. Do you conduct regular reviews or surveys to identify program improvement opportunities?

Yes No

If yes please attach sample questions or describe?

8 INSURANCE

Do you hold professional indemnity, public liability and workers compensation insurance?

Yes No

Please attach copies

9 DECLARATION

I wish to apply for HCF provider recognition. I understand that I must meet the HCF recognition criteria for my profession, and I understand that HCF Provider recognition is at HCF's sole discretion. I have read and agree to abide by the Terms and Conditions for HCF Recognised Providers of General Treatment and the HCF Privacy Policy. I consent to HCF using and disclosing the personal information it collects about my business including my name, contact and other business details through the HCF website, brochures, HCF mobile apps and other promotional literature and activities to inform Members about participation in Health Management Programs. I certify that the above details are true and complete.

The person signing below has authority to act on behalf of the proprietor and is the person who has completed the form.

Signature

Date (DD MM YYYY)

Name

Position

Phone

Mobile

Call us on **1300 799 275** for more information.