HEALTH MANAGEMENT PROGRAMS PROVIDER APPLICATION

Certain HCF extras products pay benefits towards Health Management Programs such as Weight Management, Quit Smoking, 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 return via:

Email **provider_relations@hcf.com.au**
Mail **Provider Relations**
GPO Box 4242,
Sydney NSW 2001

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

- ☐ Childbirth Education
- ☐ Lactation Consultant
- ☐ Learn to Swim
- ☐ Quit Smoking
- ☐ Stress Management
- ☐ Weight Management

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

Title | First name | Last name

Name of the program you deliver

Business name

Parent company name (if you are owned or franchised by a separate business entity) | ABN or ACN

Lot number | Suite/unit number | Building and floor number/property name (if applicable)

Unit no. | Street no. | Street name | Street type

Suburb | State | Postcode

Phone | Mobile

Postal address if different from the above

Postal address line 1 | Postal address line 2

Suburb | State | Postcode

Email | Website (if applicable)

3 TYPE OF FACILITY WHERE YOUR PROGRAM IS DELIVERED

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

Other

Do you provide mobile services? Yes ☐ No ☐

If yes, please give details

4 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

Name of the professional association/body that governs profession

Full name

Medicare provider number (if applicable)

Qualifications

Name of the professional association/body that governs profession

5 PROGRAM DETAILS

5a. Please describe the program you deliver including content, aims and objectives

Months

Years

Group size (if applicable)

Is the entire program delivered face to face?

Yes ☐ No ☐

If no, please give details

5b. For stress management or quit smoking program

Is the entire program delivered face to face?

Yes ☐ No ☐

5c. 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

6 QUALITY AND SAFETY

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

6a. 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

6b. 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?

6c. Do you conduct regular reviews or surveys to identify program improvement opportunities?

Yes ☐ No ☐

If yes please attach sample questions or describe?

7 INSURANCE

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

Yes ☐ No ☐

Please attach copies

8 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 Extras Services** 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.