

**Instructions**

Complete this form to submit applications for TAC-funded vehicle modifications to ensure the safety, accessibility and independence of TAC clients as drivers or passengers. Include details about the person's transport needs as well as whether their current or pre-accident vehicle is suitable for modification and, where relevant, if it has the capacity to fit a wheelchair.

# Section 1

## TAC client details

|  |  |
| --- | --- |
| First name |   |

|  |  |
| --- | --- |
| Last name |   |

|  |  |  |  |
| --- | --- | --- | --- |
| TAC claim number |   | Date of accident |  / /  |

|  |  |
| --- | --- |
| Date of birth |  / /  |

|  |  |
| --- | --- |
| Street name and number |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Suburb/Town |   | Post code |   |

|  |  |
| --- | --- |
| Client phone number |   |

|  |  |
| --- | --- |
| Client email address |   |

|  |  |
| --- | --- |
| Key contact if not client |   |

|  |  |
| --- | --- |
| Key contact phone number |   |

|  |  |
| --- | --- |
| Relationship of key contact |   |

(e.g. parent, partner, guardian)

|  |  |  |  |
| --- | --- | --- | --- |
| Date of assessment |  / /  | Date of report |  / /  |

|  |  |
| --- | --- |
| Has the Community Access and Transport Recommendations assessment been completed?  |   |

**If no**, please contact the TAC.

# Section 2

## current status and performance

Provide a summary of person’s current capabilities. Include how capabilities relate to injuries from the transport accident and the person’s needs for a modified vehicle. Note any relevant medical history not related to the transport accident that may affect recommendations.

Outline the injuries the person sustained in their transport accident. Include any complications from injuries,
e.g. epilepsy.

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Outline the person’s current physical capabilities. Include transfers, indoor/outdoor mobility, upper and lower limb function, balance, splinting and equipment required, such as hoists, manual or powered wheelchairs.

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Outline cognitive and behavioural capabilities. Include memory, insight and distractibility.

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Outline communication, hearing, vision, tactile and swallowing capabilities. Note any difficulties, support or
special requirements.

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# Section 3

## Current or pre-accident vehicle

For the TAC to determine reasonable contribution, please outline the details of the person’s existing or pre-accident vehicle or other vehicles to which the person has access.

|  | Person’s current vehicle | Person’s pre accident vehicle |
| --- | --- | --- |
| Make and model (e.g. Holden Commodore) |   |   |
| Variant/Badge (e.g. Omega, SV6) |   |   |
| Year of manufacture |   |   |
| Current kilometres |   |   |
| Registration plate |   |   |
| Engine capacity (1.5L, 2.0L) |   |   |
| Type of transmission (auto or manual) |   |   |
| Fuel type (diesel/petrol/hybrid) |   |   |
| Year of purchase |   |   |

| Other vehicles the person has access to (family members, work vehicles etc.) |
| --- |
| Make & model (e.g. Holden Commodore) |   |   |
| Variant/Badge (e.g. Omega, SV6) |   |   |
| Year of manufacture |   |   |
| Current kilometres |   |   |
| Registration plate |   |   |
| Engine capacity (1.5L, 2.0L) |   |   |
| Type of transmission (auto or manual) |   |   |
| Fuel type (diesel/petrol/hybrid) |   |   |
| Year of purchase |   |   |

How often does the person have access to these vehicles? If access to these vehicles is limited, please outline the reasons why.

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| Is the above vehicle currently available for this person’s use and suitable for modifications? |   |

**If no**, please provide rationale below

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# section 4

## Wheelchair specifications

If applicable, please outline the details of all wheelchairs the person will be seated in when travelling or transferring from/into vehicle.

|  |  |
| --- | --- |
| Manual(folding/rigid frame) |   |

|  |  |
| --- | --- |
| Power |   |

|  |  |
| --- | --- |
| Type & model |   |

### Wheelchair footprint

Provide overall dimensions when person sitting in wheelchair in usual travel posture and with accessories / medical equipment attached. Include diagram if appropriate.

| Type and model | Manual wheelchair | Power wheelchair |  |
| --- | --- | --- | --- |
| 1. Chair width
 |  mm |  mm |
| 1. Chair length
 |  mm |  mm |
| 1. Floor to eye height
 |  mm |  mm |
| 1. Floor to top of head
 |  mm |  mm |
| 1. Floor to seat height
 |  mm |  mm |
| 1. Floor to footplate height
 |  mm |  mm |
| 1. Floor to knee height
 |  mm |  mm |
| 1. Arm extension
 |  mm |  mm |
| 1. Thigh length
 |  mm |  mm |
| 1. Castor wheel size

 (front) |  mm |  mm |
| 1. Back wheel size / e-motion wheel size
 |  mm |  mm |
| 1. Floor to shoulder height
 |  mm |  mm |
| 1. Headrest fitted?
 |   |   |
| 1. Chair weight
 |  kg |  kg |
| 1. Combined weight in chair
 |  kg |  kg |
| 1. Floor to armrest height
 |  mm |  mm |
| 1. Is the chair suitable to have a docking pin fitted?
 |   |   |

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| --- | --- |
| Is the person’s current vehicle/car able to have recommended adaptive equipment and structural modifications installed? |   |
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# Section 5

## Alternate vehicle/cars and modifications

Provide details of all vehicles that have been considered as a part of this assessment process. Please ensure quotes are itemised.

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Outline the most appropriate make and model of vehicle to meet the person’s transport needs.Provide details and clinical justification for your recommendation and include the person’s preference. Include itemised quotes for both vehicle purchase and modifications.

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# Section 6

## Request details

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| Modifications to the person’s own vehicle |   |

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| Contribution to a standard vehicle and modifications |   |

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| --- | --- |
| Contribution to a modified wheelchair accessible van |   |

Please provide clinical rationale for recommendations

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# Section 7

## Anticipated driving status

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| --- | --- |
| Person as a driver |   |

|  |  |
| --- | --- |
| Person as a passenger |   |

|  |  |
| --- | --- |
| Person as a driver and passenger |   |

|  |  |
| --- | --- |
| Person as a passenger now, with potential to drive in the future |   |

|  |  |
| --- | --- |
| Anticipated kilometers per year  |   |

### If person is a driver:

|  |  |
| --- | --- |
| Licence category (specify, e.g. car, motorcycle) |   |
|  |

|  |  |
| --- | --- |
| Current valid driving licence? |   |

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| --- | --- |
| If yes, are there restrictions imposed? |   |

If the person has a restricted licence, please provide details of those restrictions.

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| --- | --- |
| Has the person had a driving assessment since their injury? |   |

|  |  |
| --- | --- |
| **If yes**, what is the date of their last driving assessment? |  / /  |

|  |  |
| --- | --- |
| **If no,** are they required to have a driving assessment? |   |

If there has been an OT driving assessment completed, please attach a copy of the Occupational Therapy Driving Assessment Report and VicRoads Medical Report Form.

Any additional comments

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### If person is a passenger:

If the person is a passenger only, please comment on who will be driving the vehicle, if they have been consulted and if training requirements exist?

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# Section 8

## Recommended vehicle modifications/vehicle

Please outline rationale for all recommendations

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| When travelling in the vehicle, recommended seating arrangement for the person is: | Yes or No | Comments |
| Driver seated in wheelchair |   |   |
| Driver seated in vehicle seat |   |   |
| Passenger seated in wheelchair |   |   |
| Passenger seated in vehicle seat |   |   |

|  |  Detailed recommendations and clinical justification |
| --- | --- |
| Wheelchair access into vehicle and within vehicle (ramp/hoist, door openings, rear/side entry, required clearance dimensions). |   |
| Vehicle seating arrangements:Where will person sit in vehicle? Other seats required in vehicle? Where does the person wish to sit in the vehicle? |   |
| Is specific seating required? (e.g. seat belts, special seats, head supports) |   |
| Are modified vehicle controls required?(e.g. left foot accelerator, hand controls) |   |
| What wheelchair restraints and seatbelt requirements are you recommending? (e.g. docking station/tie downs) |   |
| Are specific vehicle options required?(e.g. transmission type) |   |
| If equipment is to be transported, please comment on how it is to be loaded and stowed. For example, can the person load equipment with the help of hoists/lifts? Will a carer be required to load and stow equipment? |   |
| Is there a suitable second hand vehicle available to meet the person’s needs outlined above?  |   |

# section 9

## Other transport requirements

Indicate other people/items required to be transported in this vehicle now and in the future. Include whether
equipment items will adequately fit in available space in proposed vehicle. Include predicted needs if person’s needs are expected to change in the future. Consider equipment that has been provided, is awaiting prescription or is yet
to be investigated.

|  | Current status | Anticipated future status |
| --- | --- | --- |
| People: number and relationship of people who would be using the vehicle apart from the person |   |   |
| Equipment (e.g. ramps, wheelchair, scooter, mobile hoist, gait aids) |   |   |
| Other |   |   |

# section 10

## Vehicle availability

|  |  |
| --- | --- |
| Have you discussed with the person, their family and carers the need to ensure that the proposed vehicle is readily available for person use?(i.e. the vehicle must be free for use and readily accessible when needed) |   |
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Comments

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# Section 11

## Vehicle access at home

What parking options are available at the person’s home for the proposed vehicle? Has an appropriate location for the vehicle been established? Please describe.

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What are the spatial dimensions of the area where loading and unloading will occur, and external dimensions of the proposed vehicle? Is there room for safe loading and unloading, and wheelchair access around the parked vehicle? Please describe.

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What is the height of the existing garage or car port? Will the proposed vehicle have adequate clearance, including when the tail gate is fully open? Please describe.

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Is it recommended that the vehicle will reverse or front in to the parking / loading area? Please describe.

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Does the parking area allow for the person to load and exit the vehicle in an undercover area? Is undercover loading and exit clinically required? Please describe.

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|   |

What is the condition (e.g. surface, gradient, drainage) of the current parking area and driveway, and is it anticipated that access to the proposed vehicle would require any structural modification to this area? Please describe.

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# Section 12

## Insurance / registration

Has the person been made aware that they will be required to pay for the following? Do they indicate that they understand this?

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| --- | --- |
| Comprehensive insurance and any excess incurred by person/carers in case of an accident |   |

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| --- | --- |
| TAC levy / registration fee |   |

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| --- | --- |
| Any additional options to the vehicle not required due to transport accident injuries |   |

|  |  |
| --- | --- |
| All general maintenance and repairs of vehicle |   |

|  |  |
| --- | --- |
| Fuel |   |

|  |  |
| --- | --- |
| Has the person been made aware that they will be required to sign a Vehicle Modifications Agreement before vehicle handover if modifications exceed $10,000? |   |
|  |

|  |  |
| --- | --- |
| Is the person aware they are responsible for general running cost and maintenance to the vehicle?  |   |

Additional comments

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| --- |
|   |

# section 13

## Authorisation

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| --- | --- |
| Have you discussed this Vehicle Modifications Assessment and Recommendations with the person or the person’s representative? |   |
|  |

|  |  |
| --- | --- |
| Has the person or the person’s representative consented to supply the TAC with the personal and health information collected? |   |
|  |

# section 14

**PROVIDER details**

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| --- | --- |
| I have discussed with the person and/or representatives and other members of the treating team the information contained in this form, including the requested items, aims, predicted outcomes, maintenance and training requirements.  |   |
|  |

|  |  |
| --- | --- |
| Provider name, address, email and phone number(Type details or insert image of practice stamp) |  |

|  |  |
| --- | --- |
| SWEP credentialing level |   |

|  |  |
| --- | --- |
| Days/hours available |   |

|  |  |
| --- | --- |
| SignatureInsert image (jpg/png) of signature.(Or print, sign and scan the form) |  |



|  |  |
| --- | --- |
| Date |  / /  |

****

**Submitting this form**

Email your completed form to your TAC claims manager or to info@tac.vic.gov.au with the client’s TAC claim number in the subject line. Please also attach any supporting documentation.

**Privacy**

The TAC will retain the information provided and may use or disclose it to make further inquiries to assist in the ongoing management of the claim or any claim for common law damages. The TAC may also be required by law
to disclose this information. Without this information, the TAC may be unable to determine entitlements or assess whether the treatment is reasonable and may not be able to approve further benefits and treatment. If you require further information about our privacy policy, please call the TAC on 1300 654 329 or visit our website at [www.tac.vic.gov.au](http://www.tac.vic.gov.au)