**Community, Consumers, Carers and Family Payment Form**

WAPHA works with the Health Consumers’ Council WA to make payments to individuals. Please complete the following details to enable your participation payment to be made direct to your bank account. This form must be submitted to WAPHA along with a [completed Standard Choice Form.](https://www.ato.gov.au/assets/0/104/2244/2335/3c4347e5-f117-48af-9349-43e9f72ea811.pdf)

|  |  |
| --- | --- |
| **Title of engagement activity/ project** |  |
| **Date of activity** |  |
| **Name of WAPHA staff contact** |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Your contact details** | | | | | | | | | | | | | | | | | |
| **Name** |  | | | | | | | | | | | | | | | | |
| **Address** |  | | | | | | | | | | | | | | | | |
| **Phone** |  | | | | | | **Email** |  | | | | | | | | | |
| **Nominated bank account for payment** | | | | | | | | | | | | | | | | | |
| **Bank and branch** |  | | | | | | | | | | | | | | | | |
| **BSB** |  |  |  |  |  |  | **Account number** | |  |  |  |  |  |  |  |  |  |
| **Account name** |  | | | | | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **Paid Participant Superannuation Contribution** | |
| **Name of Superannuation Fund** |  |
| **Email or phone contact of Superannuation Fund** |  |
| **Membership Number** |  |
| **Is this a self-managed super fund** | Yes/ No |

|  |  |  |
| --- | --- | --- |
| **Please indicate your consent to the below statements by placing an (x) in the yes or no column** | **Yes** | **No** |
| I provide WA Primary Health Alliance with approval to share the above information with the Health Consumers’ Council of WA for the purposes of providing a participation payment for my involvement in the listed activity. |  |  |
| The Health Consumers’ Council holds a number of health forums and member only events throughout the year. Individual membership is free.    I would like to receive information from the Health Consumers’ Council about training opportunities and membership options. |  |  |
| **Date of consent** |  | |
| *\*WAPHA use only\* I authorise payment of $\_\_\_\_ for a total of \_\_\_\_hours at $\_\_\_\_per hour.*  *Name: Date of consent: Email:* | | |