

From the information you provide on this form, Services Australia, International Services will assess your eligibility for Carer Payment. You are also required to have a health professional complete the Health Professional Assessment form.

Please answer all questions.

1 Your details

Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="text"/>
Family name	<input type="text"/>
First given name	<input type="text"/>
Other given name(s)	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>
Contact phone number	(<input type="text"/>) <input type="text"/>

About your partner

2 Your partner's details

Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="text"/>
Family name	<input type="text"/>
First given name	<input type="text"/>
Other given name(s)	<input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/>

3 What is your partner's main disability/medical condition(s) for which they require care?

List condition(s)	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

4 Do you personally provide care for your partner on a daily basis because of the disability/medical condition?

No <input type="checkbox"/>	
Yes <input type="checkbox"/>	Date care started (due to the disability/medical condition) <input type="text"/> / <input type="text"/> / <input type="text"/>



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5 Is your partner currently in hospital?

No

Yes Date of hospitalisation

Expected release date

Do you provide care for your partner while they are in hospital?
e.g. you are involved in your partner's rehabilitation or treatment.

No

Yes Care you provide

Will your partner return to your care on their release from hospital?

No You may be asked for more information.

Yes

6 Does your partner stay overnight or longer with any other person or organisation on a regular basis?

No

Yes Please tick the box that shows the reason(s) why your partner stays overnight or longer with another person or organisation:

Treatment (other than hospitalisation)
e.g. spends night(s) at therapy

How many nights?
e.g. 3 days a week, 1 night a month

When did this start?

Education/training
e.g. spends night(s) at training centre or hostel

How many nights?
e.g. every weekend, 1 night a month

When did this start?

Shared care
e.g. another family member

How many nights?
e.g. every weekend, 1 night a month

When did this start?

Other care
e.g. • temporary care
• spends night(s) with other person not living with you
• respite care

How many nights?
e.g. every weekend, 1 night a month

When did this start?

7 Is your partner terminally ill and expected to live for 3 months or less?

No

Yes Go to **Question 11** on page 7
You do not need to complete details about the care provided.

About the care provided

Section A—day to day care needs

Please read the instructions below before answering Question 8.

8 Does your partner:

For each statement in Question 8, tick the box that best describes how well your partner usually manages.

- Your partner's abilities include what they can do **when using their aids, appliances or special equipment items**.
- Where your partner's disability or condition is only apparent at certain times, the question should be answered for when your partner is **not experiencing an episode or flare-up of the disability/condition**.
- Help* means any physical assistance, guidance or supervision.
- Without help* means your partner starts and finishes activities without assistance or supervision.

a move around the house? may use walking stick, frame, wheelchair etc.	Without help <input type="checkbox"/> a
	With help of one person <input type="checkbox"/> b
	With help of two people <input type="checkbox"/> c
	Is confined to bed <input type="checkbox"/> d
b fall over indoors or outdoors (or from a wheelchair)?	Often <input type="checkbox"/> a
	Sometimes <input type="checkbox"/> b
	Never <input type="checkbox"/> c
c move to and from bed, chairs, wheelchair and walking aids?	Without help <input type="checkbox"/> a
	With some help <input type="checkbox"/> b
	With a lot of help <input type="checkbox"/> c
	Cannot do this <input type="checkbox"/> d
d have difficulty hearing others? even with hearing aids	Always <input type="checkbox"/> a
	Often <input type="checkbox"/> b
	Sometimes <input type="checkbox"/> c
	Never <input type="checkbox"/> d
e have difficulty seeing clearly? even with glasses	Always <input type="checkbox"/> a
	Often <input type="checkbox"/> b
	Sometimes <input type="checkbox"/> c
	Never <input type="checkbox"/> d
f need help or attention during the night?	Always <input type="checkbox"/> a
	Often <input type="checkbox"/> b
	Sometimes <input type="checkbox"/> c
	Never <input type="checkbox"/> d
g have loss of bladder and/or bowel control? incontinence	Always <input type="checkbox"/> a
	Often <input type="checkbox"/> b
	Sometimes <input type="checkbox"/> c
	Never <input type="checkbox"/> d
h use continence aids or equipment? e.g. colostomy, catheter, pads	Without help <input type="checkbox"/> a
	With some help <input type="checkbox"/> b
	With a lot of help <input type="checkbox"/> c
	Does not use aids <input type="checkbox"/> d

<i>(continued)</i> Does your partner:	i use the toilet?	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot use a toilet	<input type="checkbox"/> d
	j eat their food? does not include meal preparation	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot feed themselves	<input type="checkbox"/> d
	k shower, bath themselves?	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot do this	<input type="checkbox"/> d
	l dress themselves? e.g. buttons, zips	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot do this	<input type="checkbox"/> d
	m look after their grooming? e.g. shaving, caring for hair, teeth	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot do this	<input type="checkbox"/> d
	n take care of their own medication? e.g. take the right tablet at the right time	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot do this	<input type="checkbox"/> d
		Does not take medication	<input type="checkbox"/> e
	o take care of their own treatment? e.g. oxygen, wound care, gastric feeding	Without help	<input type="checkbox"/> a
		With some help	<input type="checkbox"/> b
		With a lot of help	<input type="checkbox"/> c
		Cannot do this	<input type="checkbox"/> d
		Does not have treatment	<input type="checkbox"/> e

Section B—cognitive function

9 Does your partner:

For each statement in Question 9, tick the box that best describes how well your partner usually manages.

a understand what you, the carer, say?	Always	<input type="checkbox"/> a
	Usually	<input type="checkbox"/> b
	Sometimes	<input type="checkbox"/> c
	Never	<input type="checkbox"/> d
b understand what other people say?	Always	<input type="checkbox"/> a
	Usually	<input type="checkbox"/> b
	Sometimes	<input type="checkbox"/> c
	Never	<input type="checkbox"/> d
c let others know how they feel and what they want? e.g. by speaking, using sign and/or communication aid	Always	<input type="checkbox"/> a
	Usually	<input type="checkbox"/> b
	Sometimes	<input type="checkbox"/> c
	Never	<input type="checkbox"/> d
d know where they are?	Always	<input type="checkbox"/> a
	Usually	<input type="checkbox"/> b
	Sometimes	<input type="checkbox"/> c
	Never	<input type="checkbox"/> d
e know whether it is morning, afternoon or night?	Always	<input type="checkbox"/> a
	Usually	<input type="checkbox"/> b
	Sometimes	<input type="checkbox"/> c
	Never	<input type="checkbox"/> d
f remember things that happened today?	Always	<input type="checkbox"/> a
	Usually	<input type="checkbox"/> b
	Sometimes	<input type="checkbox"/> c
	Never	<input type="checkbox"/> d

Section C—behaviour

10 Does your partner:

For each statement in Question 10, tick the box that best describes how well your partner usually behaves.

a wander away or 'run away' from home?	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
b shout, scream at or threaten, other people?	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
c physically harm other people?	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
d damage furniture, possessions or objects?	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
e laugh or cry without apparent reason?	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
f withdraw from contact with other people, or appear depressed, worried or fearful?	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
g deliberately harm themselves? e.g. by biting, scratching skin, hitting or banging their head	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c
h have unusual, inappropriate or repetitive behaviours? e.g. uncontrolled eating, spinning objects, hand flapping, rocking, calling out or saying the same thing over and over again	Never	<input type="checkbox"/> a
	Sometimes	<input type="checkbox"/> b
	Often	<input type="checkbox"/> c

11 You need to read this

Privacy and your personal information

The privacy and security of your personal information is important to us, and is protected by law. We need to collect this information so we can process and manage your applications and payments, and provide services to you. We only share your information with other parties where you have agreed, or where the law allows or requires it. For more information, go to servicesaustralia.gov.au/privacy

Statement

12 You must read and sign the following statement.

I declare that

- to the best of my knowledge the information I have given on this form is correct.

I understand that

- giving false or misleading information is a serious offence.
- information I provide is protected under the privacy laws of both Australia and New Zealand.

Your signature



Date

/ /

13 WHAT TO DO NOW

- 1 Fill in your and your partner's details on the front of the Health Professional Assessment.**
Your partner must sign the front of the assessment to authorise release of medical details.
If you do not have this form contact your local Work and Income office in New Zealand.
- 2 Phone the health professional who treats your partner, to make an appointment.**
When you make your appointment please let the treating health professional know that you need them to complete the Health Professional Assessment.
- 3 Return this completed form and the completed Health Professional Assessment to your local Work and Income office in New Zealand.**
Your claim will be forwarded to Work and Income in New Zealand International Services.

ENQUIRIES—Phone Services Australia, International Services on **0800 441 248** if you need assistance to complete this form.