Australian Government
Services Australia

centrelink

Assessment for Carer Payment

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 ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Family name

First given name

Other given name(s)

Date of birth / / Gender Male ☐ Female ☐ Other ☐

Contact phone number ( )

About your partner

2 Your partner's details

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other

Family name

First given name

Other given name(s)

Date of birth / / Gender Male ☐ Female ☐ Other ☐

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

List condition(s)

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

No ☐

Yes ☐ Date care started (due to the disability/medical condition) / /

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

(continued) **Does your partner:**

i	**use the toilet?**	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot use a toilet	☐ d
j	**eat their food?** does not include meal preparation	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot feed themselves	☐ d
k	**shower, bath themselves?**	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot do this	☐ d
l	**dress themselves?** e.g. buttons, zips	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot do this	☐ d
m	**look after their grooming?** e.g. shaving, caring for hair, teeth	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot do this	☐ d
n	**take care of their own medication?** e.g. take the right tablet at the right time	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot do this	☐ d
		Does not take medication	☐ e
o	**take care of their own treatment?** e.g. oxygen, wound care, gastric feeding	Without help	☐ a
		With some help	☐ b
		With a lot of help	☐ c
		Cannot do this	☐ d
		Does not have treatment	☐ 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	☐ a
		Usually	☐ b
		Sometimes	☐ c
		Never	☐ d
b	**understand what other people say?**	Always	☐ a
		Usually	☐ b
		Sometimes	☐ c
		Never	☐ d
c	**let others know how they feel and what they want?** e.g. by speaking, using sign and/or communication aid	Always	☐ a
		Usually	☐ b
		Sometimes	☐ c
		Never	☐ d
d	**know where they are?**	Always	☐ a
		Usually	☐ b
		Sometimes	☐ c
		Never	☐ d
e	**know whether it is morning, afternoon or night?**	Always	☐ a
		Usually	☐ b
		Sometimes	☐ c
		Never	☐ d
f	**remember things that happened today?**	Always	☐ a
		Usually	☐ b
		Sometimes	☐ c
		Never	☐ 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	a
		Sometimes	b
		Often	c
b	**shout, scream at or threaten, other people?**	Never	a
		Sometimes	b
		Often	c
c	**physically harm other people?**	Never	a
		Sometimes	b
		Often	c
d	**damage furniture, possessions or objects?**	Never	a
		Sometimes	b
		Often	c
e	**laugh or cry without apparent reason?**	Never	a
		Sometimes	b
		Often	c
f	**withdraw from contact with other people, or appear depressed, worried or fearful?**	Never	a
		Sometimes	b
		Often	c
g	**deliberately harm themselves?** e.g. by biting, scratching skin, hitting or banging their head	Never	a
		Sometimes	b
		Often	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	a
		Sometimes	b
		Often	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.

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.
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 require them to complete the Health Professional Assessment.
3. **Return this completed form and the completed Health Professional Assessment to Services Australia, International Services.**

ENQUIRIES—Phone Services Australia, International Services on + **61 3 6222 3455** if you need assistance to complete this form.