

centrelink

Assessment for Carer Payment

1	Your details	Title Family name First given name Other given name(s) Date of birth Contact phone number	Mr Mrs Miss Dr Other / / Gender Male Female Other
_		About your par	tner
2	Your partner's details	Title Family name First given name Other given name(s) Date of birth	Mr Mrs Miss Dr Other 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	ted (due to the disability/medical condition) / /



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	continued • About your partner							
5	Is your partner currently in hospital?	No Yes	□ Da	te of hospitalisation / /				
		163						
				pected release date / / you provide care for your partner while t	thau are in hagnital?			
				. you are involved in your partner's rehab	-			
			Wil No Yes	I your partner return to your care on thei You may be asked for more infor	•			
6	Does your partner stay overnight or longer with any other person or organisation on a regular basis?	No Yes		ase tick the box that shows the reason(s				
			Sta	Treatment (other than hospitalisation) e.g. spends night(s) at therapy	on or organisation.			
				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 How many nights? e.g. every weekend, 1 night a month	or hostel			
				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 per • respite care How many nights? e.g. every weekend, 1 night a month	rson not living with you			
				When did this start?	/ /			
7	Is your partner terminally ill and expected to live for 3 months or less?	No Yes		to Question 11 on page 7 I do not need to complete details about t	the care provided.			

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About the care provided

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. • Vince your partner solitiles include what they can do when using their a rids, 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 expertencing an episode or flare-up of the disability/condition. • Without help means any physical assistance, quidance or supervision. • Without help means your partner's distributes without assistance or supervision. • Without help means your partner shafts and finishes activities without assistance or supervision. • Without help means your partner is not expertencing an episode or flare-up of the disability/condition. • Without help means your partner is not expertencing and episode or flare-up of the disability/condition. • Without help means your partner is not expertencing and episode or flare-up of the disability for the properties of the disability for the properties of the properties of the disability for the properties of the disability for the properties of the properti	Section A—day to day care needs	;			
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f need help or attention during the night? Always		е		Always	a
Never			even with glasses	Often	b
f need help or attention during the night? Always a Often b Sometimes c Never d Always a Incontinence dids or equipment? e.g. colostomy, catheter, pads Always a Often b Sometimes c Never d Without help a With some help b With some help c Decemptations aids or light and of help c				Sometimes	С
Often				Never	d
Sometimes		f	need help or attention during the night?	Always	а
Never				Often	b
g have loss of bladder and/or bowel control? incontinence Always Often Bosometimes c Never d Without help e.g. colostomy, catheter, pads With some help b With a lot of help c Decempt year side				Sometimes	С
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h use continence aids or equipment? e.g. colostomy, catheter, pads Without help a With some help b With a lot of help c			inconunence	Often	b
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With some help With a lot of help C Decempet use side		h		Without help	a
Does not use side			o.g. volvstorny, varifeter, paus	With some help	b
Does not use aids d				With a lot of help	С
				Does not use aids	d

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continued • About the care provided

continued) Does your partner:	i	use the toilet?	Without help	а
			With some help	b
			With a lot of help	С
			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	С
			Cannot feed themselves	d
	k	shower, bath themselves?	Without help	а
			With some help	b
			With a lot of help	С
			Cannot do this	d
	ī	dress themselves?	Without help	а
		e.g. buttons, zips	With some help	b
			With a lot of help	С
			Cannot do this	d
	m	look after their grooming? e.g. shaving, caring for hair, teeth	Without help	а
			With some help	b
			With a lot of help	С
			Cannot do this	d
	n	take care of their own medication? e.g. take the right tablet at the right time	Without help	а
			With some help	b
			With a lot of help	С
			Cannot do this	d
			Does not take medication	e
	0	take care of their own treatment?	Without help	а
		e.g. oxygen, wound care, gastric feeding	With some help	b
			With a lot of help	С
			Cannot do this	d
			Does not have treatment	e

continued • About the care provided

	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	а
				Usually	b
				Sometimes	С
				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	а
				Usually	b
				Sometimes	С
				Never	d
		d	know where they are?	Always	а
				Usually	b
				Sometimes	c
		e		Never	d
			know whether it is morning, afternoon or night?	Always	а
				Usually	b
				Sometimes	С
				Never	d
		f	remember things that happened today?	Always	Па
				Usually	b
				Sometimes	С
				Never	d

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continued • About the care provided

Section C-behaviour a wander away or 'run away' from home? 10 Does your partner: Never For each statement in Question 10, Sometimes tick the box that best describes how well your partner usually Often behaves. b shout, scream at or threaten, other people? Never Sometimes Often c physically harm other people? Never Sometimes Often damage furniture, possessions or objects? Never Sometimes Often e laugh or cry without apparent reason? Never Sometimes Often withdraw from contact with other people, or Never appear depressed, worried or fearful? Sometimes Often deliberately harm themselves? Never e.g. by biting, scratching skin, hitting or Sometimes banging their head Often h have unusual, inappropriate or repetitive Never behaviours? Sometimes e.g. uncontrolled eating, spinning objects, hand flapping, rocking, calling out or saying the same Often thing over and over again

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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

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 / /

WHAT TO DO NOW

- 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.
- 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.
- 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.

Date