Australian Government
Services Australia

centrelink

Health Professional Assessment
for Carer Payment

HPA
Health Professional Assessment

Fill in this page only, make an appointment for your partner and give this assessment to the health professional to complete.

STEP 1 Your details

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

Family name

First given name

Other given name(s)

Date of birth / / Male ☐ Female ☐ Other ☐

Contact phone number ( )

STEP 2 Your partner's details

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

Family name

First given name

Other given name(s)

Date of birth / / Male ☐ Female ☐ Other ☐

STEP 3 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**

Authorisation for release of medical details **by your partner**

- I give permission for medical details and clinical notes about me to be supplied to Services Australia and Work and Income in New Zealand.
- I understand that the assessment will be used to assist in assessing a claim for Carer Payment by my partner and may need to be released to my partner by Services Australia or Work and Income in New Zealand.

Patient's signature

Date / /

STEP 4 *See page 2*

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Answer no more questions.

Give this assessment to the health care professional who treats your partner to complete.

The health professional will probably prefer to complete this Health Professional Assessment after examining your partner to make sure the information provided is up to date. It is best if you let the health professional or receptionist know that you need a form completed when you make an appointment.

If you need an interpreter, you will need to organise this before you make an appointment with the health professional.

Instructions for the health professional

About Carer Payment

Carer Payment may be paid under Australian social security law to eligible people who personally provide constant care for a disabled adult on a daily basis in that person's home or in hospital.

Why a health professional assessment is needed

The health professional assessment is needed to determine if the applicant meets the legislative requirements to be eligible for Carer Payment.

The information required for this purpose is:

- whether the person being cared for has a severe disability or handicap, **and**
- whether, as a result of that disability, the person needs personal care and attention or constant supervision on a daily basis, **and**
- whether the person is likely to need care and attention or constant supervision permanently or for an extended period (as a guide, more than 6 months unless the person has a terminal illness and expected to live for 3 months or less).

For Carer Payment purposes, 'personal care and attention' refers specifically to the assistance required with routine personal activities such as eating, dressing, hygiene or mobility, but not assistance with everyday domestic tasks such as housekeeping, gardening, shopping etc.

The care would be required frequently each day and the carer will generally be unable to undertake full-time or substantial employment.

Assessing the level of disability

Services Australia will use the information provided by you (along with information from the applicant) to determine the person's ability to function independently.

This form is also used to assess cognitive impairment of the person receiving the care.

This is an oral test.

Who CAN complete this assessment

This assessment must be completed by a medical practitioner, registered nurse, occupational therapist or physiotherapist currently involved with the treatment of the person.

Who CANNOT complete this assessment

This assessment cannot be completed by:

- the person claiming the payment
- an immediate family member of the person claiming a payment, **or**
- an immediate family member of the person being cared for.

Please return this completed form to the carer.

About the person receiving care

1 **Does the person have physical, intellectual or psychiatric disabilities?**

physical ☐ intellectual ☐ psychiatric ☐

2 **Does the disability/medical condition result in the need for constant care on a daily basis to carry out routine personal activities**

No ☐
Yes ☐

3 **Does the disability/medical condition result in the need for constant care on a daily basis because the person requiring care may be a risk to themselves or to another?**

No ☐
Yes ☐

4 **Does the disability/medical condition result in the need for constant care on a daily basis from more than one person?**

No ☐
Yes ☐

5 **Which of the following best describes this person's condition?**

permanent ☐ ▶ Is the person's overall condition likely to improve? No ☐ Yes ☐

temporary ☐ ▶ For how long do you expect this person's condition to continue?

12 months or more ☐ ▶ Go to **Question 6**

6–11 months ☐ ▶ Go to **Question 6**

less than 6 months ☐ ▶ You do not have to complete any more medical details about this person.
Go to **Question 12** on page 8.

terminal ☐ ▶ Is the person in the terminal phase of a terminal illness and not expected to live for more than 3 months?

No ☐ ▶ Go to **Question 6**

Yes ☐ ▶ What is the person's main condition?

A legally qualified medical practitioner must certify this person's condition.

Details of medical practitioner

Name

Professional qualifications

Contact phone number

(   )

▶ You do not have to complete any more medical details about this person.
Go to **Question 12** on page 8.

6 Please indicate any condition(s) which you believe contributes significantly to the person's disability:

a Cardiovascular:

Condition		Code
Hypertension	☐	OCS
Ischaemic heart disease	☐	CAD
Myocardial infarction	☐	MYI
Peripheral vascular disease	☐	PVD
Other (please specify)	☐	

b Musculo-Skeletal

Condition		Code
Fracture	☐	FRC
Joint replacement	☐	OAR
Osteoarthritis	☐	OST
Osteoporosis	☐	OSO
Rheumatoid arthritis	☐	RHM
Malignancy of the musculo-skeletal system	☐	BON
Other (please specify)	☐	

c Neurological

Condition		Code
Behavioural disorder – Autism	☐	AUT
Behavioural disorder – Attention Deficit Hyperactivity Disorder	☐	ADD
Behavioural disorder – other (please specify)	☐	
Cerebral palsy	☐	CER
Cerebrovascular accident – aphasia	☐	CLS
Cerebrovascular accident – hemiplegia	☐	HPP
Dementia – Alzheimer's disease	☐	ALZ
Dementia – other	☐	SEN
Epilepsy – grand mal	☐	EGM
Epilepsy – myoclonic	☐	EMY
Epilepsy – petit mal	☐	EAS
Head injury, acquired brain injury	☐	TBI
Intellectual disability/mental retardation	☐	LIQ
Motor neurone disease	☐	MND
Multiple sclerosis	☐	MSC
Paralysis – Paraplegia	☐	PRP
Paralysis – Quadriplegia	☐	QPP
Parkinson's disease	☐	PAR
Spina bifida	☐	SPB
Huntington's chorea	☐	HUN
Malignancy of the neurological system	☐	BRN
Other (please specify)	☐	

(continued) **Please indicate any condition(s) which you believe contributes significantly to the person's disability:**

	Condition		Code
d Psychiatric	Anxiety disorders	☐	ANX
	Mood disorders (including depression)	☐	DPN
	Schizophrenia	☐	SCH
	Other (please specify)	☐	
e Respiratory	Asthma	☐	AST
	Chronic airways disease – chronic bronchitis	☐	BRO
	Chronic airways disease – emphysema	☐	EMP
	Chronic airways disease – other (please specify)	☐	
	Malignancy of the respiratory system	☐	LNG
	Other (please specify)	☐	
f Sensory	Blindness	☐	BLB
	Blindness – cataracts	☐	CAT
	Blindness – glaucoma	☐	GLA
	Deaf – blindness	☐	DFB
	Deafness or hearing disorder	☐	CHL
	Other (please specify)	☐	
g Other diseases/disorders	Alcohol dependence	☐	ALC
	Autoimmune disease (e.g. SLE)	☐	LPS
	Blood disorder – haemophilia	☐	HAE
	Blood disorder – leukaemia	☐	ALK
	Cystic fibrosis	☐	CYS
	Diabetes mellitus – insulin dependent	☐	IDD
	Diabetes mellitus – non-insulin dependent	☐	NID
	Drug dependence	☐	DRG
	HIV/AIDS	☐	HV4
	Malignancy (please specify)	☐	
	Renal failure	☐	KID
	Other (please specify)	☐	

Please give the codes for the two conditions at Question 6 (e.g. BRO) you believe most contribute to the person's level of disability:
If a code does not appear next to the appropriate condition, please initial the condition.

Personal activities for daily living

Personal activities for daily living—This is an assessment of personal activities of daily living. For each function, please indicate which best describes the person receiving the care.

The information under each function should be used as a record of what the person does, NOT a record of what the person could do.

The main aim is to establish degree of independence from any help, physical or verbal, however minor and for whatever reason.

The need for supervision renders the person NOT independent.

A person's performance should be established using the best available evidence. Asking the person, friends/relatives and nurses will be the usual source, but direct observation and common sense are also important. However, direct testing is not needed.

Usually the performance over the preceding 24–48 hours is important, but occasionally longer periods will be relevant.

Middle categories imply that the person supplies more than 50 per cent of the effort.

Use of aids to be independent is allowed.

Source: *Modified Barthel ADL Index, Standardised Assessment Scales for Elderly People. The Royal College of Physicians of London and the British Geriatric Society, 1992.*

Section A—day to day needs

It is in the customer's best interests that ALL parts of Question 7 (a–j) are answered.

7 For each function, please tick the box which best describes the person receiving care:

	Function	Option	
a	**Bowels** Assess preceding week. If needs enema, then incontinent	Incontinent (or needs to be given enema)	☐ a
		Occasional accident (once a week)	☐ b
		Continent	☐ c
b	**Bladder** Assess preceding week. Occasional = less than once a day. A catheterised person who can completely manage the catheter alone is registered as 'continent'.	Incontinent or catheterised and unable to manage	☐ a
		Occasional accident (once a week)	☐ b
		Continent	☐ c
c	**Grooming** Assess preceding 24–48 hours. Refers to personal hygiene: doing teeth, fitting false teeth, doing hair, shaving, washing face. Implements can be provided by helper.	Needs help with personal care: face, hair, teeth	☐ a
		Independent (implements provided)	☐ b
d	**Toilet use** Should be able to reach toilet/commode, undress sufficiently, clean self, dress and leave. With help = can wipe self, and could do some other of the above.	Dependent	☐ a
		Needs some help but can do some things alone	☐ b
		Independent (on and off, wiping, dressing)	☐ c
e	**Feeding** Able to eat any normal food (not only soft food). Food cooked and served by others, but not cut up. Help = food cut up, person feeds self.	Unable	☐ a
		Needs help in cutting, spreading butter etc.	☐ b
		Independent (food provided within reach)	☐ c
f	**Transfer** From bed to chair and back. Unable = no sitting balance (unable to sit), two people to lift. Major help = one strong/skilled or two normal people. Can sit up. Minor help = one person easily, or needs any supervision for safety.	Unable – no sitting balance	☐ a
		Major help (physical, one or two people), can sit	☐ b
		Minor help (verbal or physical)	☐ c
		Independent	☐ d
g	**Mobility** Refers to mobility about house or indoors. May use aid. If in wheelchair, must negotiate corners/doors unaided. Help = by one untrained person, including supervision, moral support.	Immobile	☐ a
		Wheelchair independent, including corners etc. (i.e. uses wheelchair without assistance)	☐ b
		Walks with help of one person (verbal or physical)	☐ c
		Independent	☐ d

(continued) **For each function, please tick the box which best describes the person receiving care:**

	Function	Response	
h	**Dressing** Should be able to select and put on all clothes, which may be adapted. Half = requires help with buttons, zips etc. but can put on some garments alone.	Dependent	☐ a
		Needs help but can do about half unaided	☐ b
		Independent (including buttons, zips, laces etc.)	☐ c
i	**Stairs** To be independent, must be able to carry any walking aid used.	Unable	☐ a
		Needs help (verbal, physical, carrying aid)	☐ b
		Independent up and down	☐ c
j	**Bathing** Usually the most difficult activity. Bath: Independent = must get in and out unsupervised and wash self. Shower: Independent = unsupervised/unaided.	Dependent	☐ a
		Independent	☐ b

Section B—Cognitive function

8 In your opinion, is the person cognitively impaired?

No ☐ ▶ Go to **Question 11** on page 8

Yes ☐

9 This is an assessment of cognitive function.

Ask the person receiving the care for the following information:

Please answer all parts of the AMT.

Memory phrase may be repeated up to three times to ensure the person has heard it correctly. All other questions may only be asked once, without further prompting.

The Abbreviated Mental Test (AMT – 7): 'Its use and validity' Jitapunkel s, Pillary I, Ebrahim S. Age and Ageing 1991; 20:332-336

The Abbreviated Mental Test (AMT)

	Correct	Incorrect
• Time of day (to the nearest hour)	☐ a	☐ a

Memory phrase

Repeat this phrase after me and remember it for later–*42 West Street*

	Correct	Incorrect
• Name of institution or suburb where the person lives	☐ b	☐ b
• Recognition of two persons in the room (doctor, nurse, carer etc.)	☐ c	☐ c
• Date of birth (day, month, year)	☐ d	☐ d
• Name of present Prime Minister of New Zealand	☐ e	☐ e
• Count backwards from 20 to 1	☐ f	☐ f
• Ask the person to repeat the **Memory phrase**	☐ g	☐ g

10 Unable to administer Abbreviated Mental Test (AMT – 7)?

☐ ▶

- Person unable to communicate ☐ a
- Person refused to participate ☐ b

Section C—Behaviour

11 For each statement, please tick the box which best describes the person's usual state.

Does the person:

a Show signs of depression?

Response	
Never	☐ a
Sometimes	☐ b
Most of the time	☐ c

(continued) **For each statement, please tick the box which best describes the person's usual state.**

b Show signs of memory loss?
- Never ☐ a
- Sometimes ☐ b
- Most of the time ☐ c

c Withdraw from social contact?
- Never ☐ a
- Sometimes ☐ b
- Most of the time ☐ c

d Display aggression towards self or others?
- Never ☐ a
- Sometimes ☐ b
- Most of the time ☐ c

e Display disinhibited behaviour?
- Never ☐ a
- Sometimes ☐ b
- Most of the time ☐ c

Your professional details

12 Is there any information in this report, which, if released to the person requiring care, might be prejudicial to their physical or mental well-being?

Australian law provides for the disclosure of medical or psychiatric information directly to the person requiring care. If there is any information in your report, which, if released to the person, may harm their physical or mental well-being, please identify and briefly state below why it should not be released directly to this person. Similarly, please specify any other special circumstances, which should be taken into account when deciding on the release of your assessment.

No ☐

Yes ☐ ▶ Identify the information and state why it should not be released directly to the person requiring care

13 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 collect this information to provide payments and services. 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**

14 Health professional's details and declaration

Please print in BLOCK LETTERS or use stamp.

Name

Qualifications

Address

Postcode

Contact phone number

Signature and date

/ /

Stamp (optional)

RETURNING THIS ASSESSMENT—Please give this completed assessment to the carer.

Thank you for your assistance.