



**Who should complete this form?**

This form should be completed by a person with a disability, illness or injury who is looking for work and is applying for a Centrelink payment or claiming a pension from another country.

Please return the completed form **within 28 days** of receiving it, to ensure that you get assistance from the earliest date possible.

**1 Customer details**

Centrelink Reference Number (if known)

_ _	-	_ _	-	_ _	-	_
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Family name

Maiden name (if applicable)

Previous married name  
(if applicable)

Other aliases (if applicable)

Given name(s)

Date of birth

Day	Month	Year
/	/	

Male

Female

Address

Postcode

Is there a telephone number  
we can contact you on?

No

Yes

(     )
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Do you need an interpreter?

No

Yes

Preferred language

**2 Please list any disabilities,  
illnesses or injuries that you have**




CLK0AUS142US 1807

**3** When did these disabilities, illnesses or injuries start to make it difficult for you to work or study full-time?

Month	/	Year
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OR I have had my disabilities or illnesses since birth

**4** Are you getting any treatment for your disabilities, illnesses or injuries?

No

Yes  Please give details

e.g. medication, physical therapy, counselling


*If you need more space please attach a separate sheet of paper with details.*

**5** Have you ever been hospitalised because of these disabilities, illnesses or injuries?

No

Yes  Date of last admission

Day	/	Month	/	Year
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Name of hospital

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Duration of stay

From

Day	/	Month	/	Year
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To

Day	/	Month	/	Year
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Reason for admission  
e.g. operation, investigation, treatment


Number of admissions in the last 5 years

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**6** Are you expecting to have an operation in the future?

No

Yes  Type of operation/procedure


Expected date (if known)

Day	/	Month	/	Year
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Where will operation take place (if known)


Reason for operation


**7 How often does your disability, illness or injury make it difficult for you to:**

no problem    sometimes    often    all the time    **Please give further details (if applicable)**

sit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
walk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
drive a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
use public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
pick up objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
handle objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
lift	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
carry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
operate everyday appliances or machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
read	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
write	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
speak	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
hear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
remember	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
interact with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
attend work or other appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
understand or follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
breathe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
manage your personal affairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
care for yourself*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
care for others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

\* If you have someone caring for you full-time, they may be eligible for a payment for carers. *Please contact International Services if you need further details.*

**8 In a workplace, would your disabilities, illnesses or injuries make it difficult for you to:**

no    sometimes    often    all the time

**Please give further details** (if applicable)

**A interact with others?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**B maintain appropriate behaviour?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**C cope with work related stress or pressure?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**D learn new tasks?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**E remember how to do tasks?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**F understand and follow instructions?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**G concentrate?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**H persist at tasks without unscheduled breaks?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**I undertake more than one task?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**J look after your personal care needs?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**K physically complete tasks?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**L move safely around the workplace?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**M communicate with others?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**N control the use of your language?**

          

\_\_\_\_\_  
 \_\_\_\_\_

**9 Who is the doctor who you usually see about your disabilities, illnesses or injuries?**  
e.g. your general practitioner.

Name   
Address   
  
  
Postcode   
Telephone (  )   
Do you give permission for us to contact this person? No  Yes

**10 Have any specialists or other doctors treated you for these disabilities, illnesses or injuries?**

No   
Yes  **Name**   
**Address**   
  
  
Postcode   
Telephone (  )   
Date of last visit Day / Month / Year   
Conditions for which you were treated

*If you have specialist reports, please attach copies.*

**11 Is there anybody else you have consulted or that has assisted you with any of your disabilities, illnesses or injuries?**  
e.g. • counsellor  
• social worker  
• community health worker  
• teacher  
• psychologist  
• physiotherapist

No   
Yes  **1** **Name**   
**Profession**   
**Address**   
  
  
Postcode   
Telephone (  )   
Do you give permission for us to contact this person? No  Yes   
**2** **Name**   
**Profession**   
**Address**   
  
  
Postcode   
Telephone (  )   
Do you give permission for us to contact this person? No  Yes

*If you need more space, please attach a separate sheet of paper with details.*

**12 Is there any other information you feel we need to know about your disabilities, illnesses or injuries?**

No   
Yes  Please give details

*If you need more space, please attach a separate sheet of paper with details.*

**13 School or full-time education details**

How old were you when you left school or full-time education?  years old

Year of leaving school/education

What grade/year did you reach?

What is the highest educational qualification you obtained?  
e.g. Year 10 Certificate, Higher School Certificate, Degree

**14 Have you gained any other qualifications, skills or experience?**

Include things like voluntary work, courses, trade tickets, licences, diplomas, tertiary qualifications.

No

Yes  Please give details

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

*If you need more space, please attach a separate sheet of paper with details.*

**15 Have you ever worked?**

No  Go to **Question 18**

Yes  What date did you last work?

Month	Year
<input type="text"/>	<input type="text"/>
/	

**16 What were your last 2 jobs?**

<b>Your last job</b>	
Type of job	<input type="text"/>
Days worked per week	<input type="text"/>
Was this work:	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual <input type="checkbox"/>
Name of employer	<input type="text"/>
Contact phone number	( <input type="text"/> )
Reason for leaving this job (e.g. retirement, resignation, caring for family, medical condition – specify which medical condition)	<input type="text"/> <input type="text"/>
<b>Your 2nd last job</b>	
Type of job	<input type="text"/>
Days worked per week	<input type="text"/>
Was this work:	Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Casual <input type="checkbox"/>
Name of employer	<input type="text"/>
Contact phone number	( <input type="text"/> )
Reason for leaving this job (e.g. retirement, resignation, caring for family, medical condition – specify which medical condition)	<input type="text"/> <input type="text"/>

*If you need more space, please attach a separate sheet of paper with details.*

**17** Have you been given or offered extra support in the workplace because of your disability, illness or injury, such as modification to your environment, reduced hours of work, alternative duties, retraining etc?

No

Yes  Please give details


*If you need more space, please attach a separate sheet of paper with details.*

**18** Have you participated in any programs to help you find work, stay in a job, return to work, manage your injury or help you with vocational rehabilitation, gaining new skills, work experience or training?

No

Yes

<b>1</b>	Name of provider	<input type="text"/>
	Type of program	<input type="text"/>
	Dates you participated	From <input type="text"/> Day / <input type="text"/> Month / <input type="text"/> Year To <input type="text"/> Day / <input type="text"/> Month / <input type="text"/> Year
<b>2</b>	Name of provider	<input type="text"/>
	Type of program	<input type="text"/>
	Dates you participated	From <input type="text"/> Day / <input type="text"/> Month / <input type="text"/> Year To <input type="text"/> Day / <input type="text"/> Month / <input type="text"/> Year

*Attach any documentation you have which provides details of your participation in the program, including when the program started and finished, the requirements of the program, what activities you undertook while in the program and for how long.*

**19** Is there any reason why you could not do a rehabilitation or training program in the future?

No

Yes  Is this because you are about to have other treatment?

No

Yes  Please give details


*If you need more space, please attach a separate sheet of paper with details.*

Is this drug or alcohol related?

No

Yes

Is there another reason?

No

Yes  Please give details


*If you need more space, please attach a separate sheet of paper with details.*

**20** When do you think you will be able to start part-time or full-time work or study?

now

within   
6 months

6–12 months

12–24 months

more than   
2 years

never

**21 Did someone help you complete this form?**

No

Yes  Who helped you?

Name

Address

  

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Postcode

Telephone

Do you give permission for us to contact this person? No  Yes

**22 IMPORTANT INFORMATION**

**Privacy and your personal information**

Your personal information is protected by law (including the *Privacy Act 1988*) and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department, or given to other parties where you have agreed to that, or where it is required or authorised by law (including for the purpose of research or conducting investigations).

You can get more information about the way in which the department will manage your personal information, including our privacy policy, at [humanservices.gov.au/privacy](http://humanservices.gov.au/privacy)

**23 Your statement**

If the customer cannot sign this form, it should be signed by their legal representative and a copy of their guardianship or power of attorney papers should be attached.

**I declare that:**

- the information I have given is correct.

**I understand that:**

- giving false or misleading information is a serious offence.

**Your signature**



Date

Day	Month	Year
/	/	

**Return this form to:**

**Department of Human Services  
International Services  
PO Box 7809  
Canberra BC ACT 2610  
AUSTRALIA**

- 1 Check that you have read and signed your statement above.
- 2 Attach any further information you feel supports your application. If you cannot provide all of the documents immediately, do not delay returning your form. Please supply any remaining documents as soon as possible to Department of Human Services, International Services, PO Box 7809, Canberra BC ACT 2610, AUSTRALIA.

**ENQUIRIES**

If you have any questions, please call the Department of Human Services direct (free of charge) on **1866 3433 086** (between 8.00 am and 5.00 pm Hobart Time, Monday to Friday).

This service may not be available from all locations in the USA.

If this service is not available call the Department of Human Services on **(+61 3) 6222 3455** (outside Australia) or **131 673** (inside Australia)

**Note:** Call charges apply – calls from mobile phones may be charged at a higher rate.