

When to use this form

Use this form to provide information about the person in psychiatric confinement to help Services Australia assess their eligibility for Centrelink payments by confirming if:

- they are still in psychiatric confinement
- they have entered a psychiatric institution
- their circumstances have changed, for example, their rehabilitation has ceased or their conviction status has changed.

This form is **not** a claim for Centrelink payments.

Important information

This form must be completed by an authorised representative of the correctional authority/facility.

Return the completed form to us **within 14 days** of being given this form.

For more information

Call us on **132 717**.

Filling in this form

You can complete this form on your computer using Adobe Acrobat Reader, or you can print it.

For help on how to fill in our forms, go to **servicesaustralia.gov.au/formhelp**

If you have a printed form:

- Use black or blue pen.
- Print in BLOCK LETTERS.
- Where you see a box like this **Go to 1** skip to the question number shown.

1 Customer's Customer Reference Number (if known)

2 Customer's name

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx ☐ Other

Family name

First given name

Second given name

3 Customer's date of birth (DD MM YYYY)

4 Has the customer been known by any other name(s)?

Include:

- name at birth
- name before marriage
- previous married name
- Aboriginal or skin name
- alias
- adoptive name
- foster name.

No ☐ **Go to next question**

Yes ☐ **Give details below**

Other name

Type of name (for example, name at birth)

If you need more space, provide a separate sheet with details.

5 Customer's gender

Male ☐

Female ☐

Non-binary ☐

6 Date customer admitted to psychiatric institution (DD MM YYYY)

7 Name of psychiatric institution

Phone number (including area code)

Name of contact person

Title/profession of contact person



CLK0SA379 2601

8 Is the customer confined because they have been **charged** with a criminal offence?

No ☐ Go to 16

Yes ☐ Go to next question

9 Is the customer currently serving a prison sentence for any crime?

No ☐ Go to next question

Yes ☐ Give details below

Date of conviction (DD MM YYYY)

<div></div>	<div></div>	<div></div> <div></div> <div></div> <div></div>
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Period of sentence

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End date (DD MM YYYY)

<div></div>	<div></div>	<div></div> <div></div> <div></div> <div></div>
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Go to 16

10 Why was the customer confined?

Tick one only

The customer's mental fitness to stand trial is being assessed ☐

The customer was found unfit to stand trial due to mental impairment ☐

The customer was found not guilty on the grounds of mental impairment ☐

The customer was found guilty but has not been convicted as their mental fitness to be sentenced is being assessed ☐

The customer was found guilty but no conviction was recorded due to their mental impairment ☐

None of the above ☐

Give details for reason of confinement

11 Is the customer confined because of a court order?

No ☐ Go to next question

Yes ☐ Give details below, not already covered in question 10

12 Has the customer been found fit for trial since being confined?

No ☐ Go to next question

Yes ☐ Date customer entered custody
(if different to question 6)

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 (DD MM YYYY)

Go to 16

13 Is mental fitness for trial still being assessed for the customer?

No ☐

Yes ☐

14 Is the customer undertaking a course of rehabilitation as defined below?

A **course of rehabilitation** is defined as a planned series of activities, that may include medical and other treatments, directed towards improving the person's physical, mental and/or social functioning.

No ☐ Go to next question

Yes ☐ Give details below

Period of rehabilitation covered by the plan

From (DD MM YYYY)

<div></div>	<div></div>	<div></div> <div></div> <div></div> <div></div>
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To (DD MM YYYY)

<div></div>	<div></div>	<div></div> <div></div> <div></div> <div></div>
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Details of the treatment/rehabilitation plan

If you need more space, provide a separate sheet with details.

15 Details of person responsible for treatment/rehabilitation plan

Full name

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Title/profession

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Contact phone number (including area code)

<div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div> <div></div>

16 Details of person completing this form (if different to question 15)

Full name

Title/profession

Contact phone number (including area code)

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Privacy policy

17 You need to read this

Important information

for the person completing this form

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/privacypolicy

Declaration


18 I declare that:

- the information I have provided in this form is complete and correct.

I understand that:

- giving false or misleading information is a serious offence.

Signature of person completing this form



Date (DD MM YYYY)

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Returning this form

Check that all required questions are answered and that the form is signed.

Return this form and any supporting documents

by post to

Services Australia
Disability Services
PO Box 7806
CANBERRA BC ACT 2610