

Cardholder Application Form

June 2018



HOW TO APPLY

1. Be sure you understand the terms and condition of the Companion Card
2. Obtain two, high quality, colour passport photos, have them signed by a health professional or service provider and include them with this form
3. Have the application form signed by the same health professional or service provider
4. Attach any copies of reports you have, which show you will need a carer to access the community for the rest of your life. (Cards are only approved when the applicant has a life-long need for attendant care)
5. Return this application to:
**Companion Card
Locked Bag 4028
Ashfield NSW 1800**

→ **Original applications and photographs will not be returned**

Please note: incomplete applications, including those without signatures, signed photographs or poor quality photographs, cannot be processed.

Your application will be processed within 20 working days.

ELIGIBILITY CRITERIA

You may be eligible for a Companion Card if:

1. you are an Australian citizen or resident, and live in NSW; and
2. you are a person with a significant and permanent disability; and
3. you are unable to participate at most community venues or activities without attendant care support; and
4. aids and other technologies do not meet your attendant care needs; and
5. your need for this level of attendant care will be life-long.



If you see this symbol at the top of a page, you may be required to attach some additional documentation.

PRIVACY

The NSW Department of Family and Community Services (FACS) is collecting your personal information on this form to assist in assessing your eligibility and to administer the Companion Card program. Your personal information will not be disclosed to any third party without your consent or unless required by law. Information collected may be accessed by a *Government Information (Public Access) Act 2009 (GIPA Act)* request. The information in this form is managed by FACS in accordance with the *Privacy and Personal Information protection Act 1998 (PPIP Act)*.



If you have questions about this form please contact NSW Companion Card:

1800 893 044

Translating and Interpreting Service: 13 11 14
applications.companioncard@facs.nsw.gov.au

www.companioncard.nsw.gov.au

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APPLICANT INFORMATION

ITEM 1. The Companion Card will only be issued in the name of the person with the disability. One application must be completed per applicant.

Applicants title (eg. Dr/Mr/Mrs/Ms/Miss/other)

Surname

First name

Name as you would like it to appear on the card

Gender male female indeterminate/intersex/unspecified

Date of birth / / (if date of birth is not known, approximate age in years)

Telephone number

Email (if available)

Residential address

Suburb

State

Postcode

Postal address
(if different from above)

Suburb

State

Postcode

Who do you nominate as your primary contact regarding this application (other than yourself)

Name

Phone number

Relationship

ITEM 2. Cultural information (optional). Cultural information received will be used to improve policy and service delivery.

Do you identify as:

Aboriginal

Torres Strait Islander

Aboriginal and Torres Strait Islander

Do you speak a language other than English at home?

Yes

No

If yes please specify language spoken

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ITEM 3. If your need for an attendant carer is not permanent, you are not eligible to receive a Companion Card.

Please tick the boxes and describe your disability. We have provided some examples of diagnoses or conditions to assist you to complete this section. Please attach copies of any formal assessments of your condition/s (e.g. visual readings, IQ assessments etc.)

(You can tick more than one box)

Physical (eg.: Muscular Dystrophy, quadriplegia, Cerebral Palsy)

Diagnosis

Neurological (eg.: Alzheimer's disease, Huntington's disease)

Diagnosis

Sensory (eg.: deaf, blind, legally blind)

Diagnosis

Acquired Brain Injury (eg.: Stroke, head injury)

Diagnosis

Intellectual (eg: Fragile X syndrome, Rett syndrome)

Diagnosis

Mental Health (eg: Schizophrenia)

Diagnosis

Other: Give a description of the condition that has resulted in your disability.

**Report
attached**

Note: If you do not have a formal diagnosis, briefly describe your condition.

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ITEM 4. This section is for applicants who live in high level residential support with staff onsite 24 hours.

If you live in one of these services the manager of the facility can sign this form and your photo.
If you do not live in 24/7 residential support, your doctor must sign **ITEM 6** instead.

Do you currently receive (or have approval to receive) one of the specific services or supports listed below?
If you do not receive one of the specifically named services below, please tick 'No'.

No > **proceed to ITEM 5** to continue with your application.

Yes > **Please tick below the specific service you receive.**

Government funded group home, 24/7 care

Government funded Large Residence, 24/7 care

Nursing home, 24/7 care

Department of Veterans Affairs
Attendant allowance

SERVICE PROVIDER DETAILS

To be completed by Manager, or equivalent, of service as indicated above:

Name

Position in organisation

Employer/organisation name

Address

Suburb

State

Postcode

Phone number

Email

DECLARATION FROM CURRENT SERVICE PROVIDER

My signature below confirms all the following: I have read all the information contained within this form, and verify that it is correct to the best of my knowledge; and I verify that the applicant has a permanent disability and will always require attendant care to participate at most community venues and activities; and I am not the applicant, or an immediate family member of the applicant; and I agree to offer all reasonable assistance and records to assist the Companion Card program to determine the applicant's eligibility; and I have written the applicant's name and signed on the reverse of the photographs to verify that it is a photograph of the applicant.

Signature

Date

/ /

Organisation stamp (if available):

If you have completed this page please go directly to Item 7

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ITEM 5.

To receive a Companion Card you must demonstrate that due to your disability you are unable to participate at most community activities without attendant care support from a companion/carer.

Attendant care support includes life-long assistance with mobility, communication, self-care, planning, where the use of aids, equipment or alternative strategies does not enable you to carry out these tasks.

It does not include providing only reassurance, social company or encouragement or care that is required due to a persons young age.

Companion Cards cannot be issued if you may become independent in the future as a result of treatment/management, training, recovery or developmental improvements.

Using the boxes below, describe the applicant's need for lifelong attendant care in the areas of mobility, communication, self-care and planning when accessing a community event or venue.

- **Include examples of the attendant care the companion provides.**
- **If the applicant's condition is episodic, describe the frequency of the episodes.**
- **How does the applicant currently access community venues and activities?**
- **Describe the applicant's use of aids or equipment.**
- **Point form is acceptable.**

Scale of assistance required: MINIMAL – can perform 75% or more of task SOME – can perform 50% to 74% of task SUBSTANTIAL – can perform 25% to 49% of tasks.

Mobility

Minimal

Some

Substantial assistance required

Communication

Minimal

Some

Substantial assistance required

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ITEM 5. (continued)

Self-care

Minimal

Some

Substantial assistance required

Planning

Minimal

Some

Substantial assistance required

Describe your use of aids or equipment (if any)

Is there anything else you would like to add in the space below to support this application?

Note: It is helpful to include details and contact information of any other disability support Services below, e.g.: Day Programs, Respite Care, Speech Therapy, Occupational Therapy, Physiotherapy, etc. School, School support unit, School Counsellor.

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ITEM 6. Health Professional Declaration

(If you receive one of the services listed in ITEM 4, your Health Professional does not need to complete ITEM 6)

Do not sign this form unless you can verify the applicant is permanently unable to participate at most venues and activities without a companion to provide attendant care support

I am currently practising as one of the following: please tick

- | | | |
|----------------------------------|----------------------------|-------------------------|
| Registered Medical Practitioner | Registered Psychologist | Qualified social worker |
| Qualified speech pathologist | Registered Physiotherapist | Registered Nurse |
| Qualified occupational therapist | Registered Opthamologist | |

I have seen the applicant in a professional capacity for _____ years _____ months

Describe the lifelong attendant care required by the applicant to enable them to access community venues and activities:

Using the boxes below, please describe in detail the impact of the applicant's disability on:

Scale of assistance required:

MINIMAL– can perform 75% or more of task **SOME** – can perform 50% to 74% of task **SUBSTANTIAL** – can perform 25% to 49% of tasks

Mobility

Minimal

Some

Substantial assistance required

Communication

Minimal

Some

Substantial assistance required

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ITEM 6. Health Professional Declaration (continued)

Self-care

Minimal

Some

Substantial assistance required

Planning

Minimal

Some

Substantial assistance required

Provide details about the treatment and recovery available to the applicant and indicate if the applicant will require attendant care support for the rest of his/her life to enable them to access community venues and activities:

My signature below confirms all the following: I have read all the information contained within this form and verify that it is correct to the best of my knowledge; I verify that the applicant has a significant and permanent disability and will always require attendant care at most community venues and activities; I am not the applicant nor am I an immediate family member of the applicant; I agree to provide all information reasonable to assist the Companion Card unit in determining the applicant's eligibility; I have written the applicants name and signed the reverse of both photographs to verify that they are of the applicant.

Provider number

Phone Number

Name

Employer/ business name

Address

Email

Signature

Date / /

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ITEM 7. Statement by applicant/guardian/agent

My signature below confirms all the following: I authorise the Companion Card program to verify the information I have supplied on this form and to obtain any information relating to my application for the purpose of assessing my eligibility for a Companion Card. This may include obtaining information held in databases by government departments and agencies, and disclosing information contained in this form or obtained in connection with this application for the purpose of assessing eligibility; I agree that health professionals or service providers may disclose information about me to the Companion Card program to assist with the assessment of my application and I understand and accept the Cardholder Terms and Conditions.

For applicants over 18 years of age

Applicant
signature

Date / /

OR

For applicants under 18 years of age, or if the applicant is unable to sign

Legal guardian/
agent signature

Date / /

Name of legal guardian/agent

Relationship to applicant

Telephone/TTY
()

I consent to receiving special offers and discounts for Companion Card holders (optional)

I consent to participating in an evaluation of the Companion Card Program (optional)

I consent to receive the Companion Card Newsletter (optional)

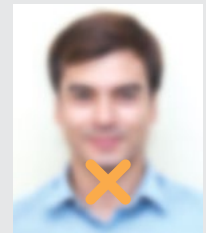
Include two colour passport photographs.

Do not use tape, staples, glue or pins.

The photographs must be a full front view of the Applicants head and shoulders only.



Write your name on the reverse of both photographs and have them signed by the professional who signed your form



If you are completing this form on behalf of the applicant, please provide your details below:

Name

Relationship to applicant

Telephone/TTY
()