Eligibility criteria

You can apply for a card if you can demonstrate:

- You live in NSW, or you reside in NSW under a valid visa; and
- You have a severe or profound disability; and
- Due to the impact of your disability, you would be unable to participate at most community venues or activities without significant assistance with mobility, communication, self care, planning; and
- The use of aids and other technologies does not meet those needs; and
- Your need for this level of support will be life-long

Cardholder Application Form – 2016 onwards

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 and include them with this form
3. Have the application form signed by the same health professional
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 life-long need for attendant care is demonstrated)
5. Return this application to:
   Companion Card
   PO Box 20637
   World Square NSW 2002

Original applications and photographs will not be returned under any circumstances.

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

PRIVACY

National Disability Services (NDS) is collecting information on this form to assist in the administration of the Companion Card program. 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 Freedom of Information request.

The information on this form is managed by NDS in accordance with the privacy act.
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  
Surname  
First name  
Name as you would like it to appear on the card  
Gender  
Date of birth  
Telephone number  
Email (if available)  
Residential address  
Suburb  
State  
Postal address (if different from above)  
Suburb  
State  
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 an Indigenous Australian?  
Yes  
No  
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
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.

(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.

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

Provide the date of your diagnosis  /  /  
Is your condition episodic?  ☐ Yes  ☐ No  
Describe the frequency of the episodes  times per month
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
☐ Nursing home, 24/7 care

☐ Government funded Large Residence, 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; and I understand it is an offence to provide any false information in this application.

Signature
Date  /  / 

If you have completed this page please go directly to Item 7 on Page 8.
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 and learning, 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 person's 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.

Provide examples of the attendant care your companion/carer provides:

Describe your use of aids or equipment (if any):

Is there anything else you, your health professional or your service provider 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, eg: Day Programs, Respite Care, Speech Therapy, Occupational Therapy, Physiotherapy, etc. School, School support unit, School Counsellor
This section is to give us more detail about your specific needs related to your disability.

I need someone to help me with (please tick):

<table>
<thead>
<tr>
<th>Task</th>
<th>never</th>
<th>partly*</th>
<th>totally#</th>
<th>Please provide examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal care</td>
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<tr>
<td>Housework</td>
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<td>Money handling</td>
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<tr>
<td>Concentrating</td>
<td></td>
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<tr>
<td>Remembering things</td>
<td></td>
<td></td>
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<tr>
<td>Understanding or following instructions</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>My health care i.e. breathing, taking medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interacting with others</td>
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<td>Reading</td>
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<td>Speaking</td>
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<tr>
<td>Hearing</td>
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<tr>
<td>Moving around, standing, walking, and carrying things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting to places out of walking distance</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

* partly – can do but need assistance to complete  * totally – cannot do on my own at all.

Please provide the name, date and formal outcomes of any formal assessments of your condition (eg. visual readings, IQ assessments, etc) – Please attach copies of reports
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)

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

☐ Registered medical practitioner
☐ Registered psychologist
☐ Registered ophthalmologist
☐ Registered nurse
☐ Registered physiotherapist
☐ Registered occupational therapist
☐ Registered psychologist
☐ Qualified social worker
☐ Qualified occupational therapist
☐ Qualified speech pathologist

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

Provide details about the past, current or proposed treatment and recovery available to the applicant and indicate if the applicant will require attendant type care for the rest of his/her life.

----------------------------------------------------------

Describe the attendant care required by the applicant

----------------------------------------------------------

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 permanent disability and will always require attendant care at most recreational 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; and I understand it is an offence to provide false information on this application.

Health professional details

Provider number

Name

Employer/ business name

Address

Suburb

State Postcode phone number

Email

Signature Date / / 

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
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; I understand and accept the Cardholder Terms and Conditions; and I understand it is an offence to provide any false information in this application.

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

( )

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

Name

Relationship to applicant

Telephone/TTY

( )

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

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

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.

For further information or assistance please visit www.nswcompanioncard.org.au or telephone NSW Companion Card on 1800 893 044.