



Australian Government

Comcare

PUTTING YOU *FIRST*

APPLICATION FOR HOUSEHOLD OR ATTENDANT CARE AND CHILD CARE SERVICES

This form is used to collect information needed to determine your entitlement to Household, Attendant Care or Child Care services in accordance with the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act). This application must be signed by the claimant and the treating doctor.

DISCLOSING AND SHARING INFORMATION

Comcare needs to collect your personal information to manage your compensation claim and to perform its functions.

Your personal information may also be used by Comcare to administer and enforce other relevant legislation including the *Occupational Health and Safety Act 1991* (OHS Act) and associated regulations.

To manage your claim, Comcare may need to disclose your personal information to the following parties:

- > your employer at the time when your injury occurred, and any subsequent employer
- > your superannuation fund manager or trustee
- > any health professional, hospital or other health institutions that you have dealt with for your injury
- > your case manager
- > your rehabilitation provider
- > vocational or functional assessor
- > employment agencies
- > legal advisers
- > persons engaged by us to conduct research related activities
- > the Safety, Rehabilitation and Compensation Commission
- > Investigators appointed under section 40 of the OHS Act
- > any relevant third party (or insurer) considered by us to have contributed to your injury
- > any other person assisting us to perform our functions or exercise our powers.

To manage your claim, Comcare and the parties listed above may need to share records containing your personal information. For more information call 1300 366 979 or visit our website at www.comcare.gov.au

EMPLOYEE'S DETAILS

Your Comcare claim reference number /

Your full name

Title (e.g. Mr, Mrs, Ms) Family name

Given name(s)

Your residential address

State Postcode

Phone contact details

Home phone number () Work phone number

What is the size of your residence? (e.g. two bedroom flat, three bedroom house, etc)

Who are the people living with you (if any), their ages and occupations? What is their relationship to you?

HOUSEHOLD AND ATTENDANT CARE SERVICES

What household or attendant care tasks are required due to your accepted condition?

Specific task	Who performed task prior to injury?	How often?	How long does the task take?
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

What is the full business name of the provider of these services?

Daytime contact number ()

What is the full business address? Please include the ABN if applicable.

State Postcode ABN

Are you, or other members of your household, currently receiving household or attendant care services?

If services are being provided through another insurer or policy, please specify the company, the current services and the hours.

CHILDCARE SERVICES

What child care services are required due to your accepted condition?

Reason for obtaining child care services?	Who cared for the child/children prior to your injury?	How often?

What is the full business name of the provider of these services?

Daytime contact number

()

What is the full business address? Please include the ABN if applicable.

State

Postcode

ABN

EMPLOYEE'S DECLARATION

I declare that:

- > The information I have supplied on this form and any other attachment is true and accurate.
- > I am aware making a false or misleading claim or statement in support of my claim is punishable by law under the *Criminal Code Act 1995*.
- > I am aware any monies paid by Comcare as a result of a false or misleading statement or claim will be recovered.

Signature

Date

ENDORSEMENT BY TREATING PRACTITIONER

Please specify whether the household, attendant care tasks or child care services stated above are currently required as a result of the accepted injury or illness?

What particular limitations prevent or restrict the injured worker's capacity to perform the household, attendant care tasks or caring for the child/children?

What household attendant care or child care services do you recommend be provided to the injured worker for their accepted condition?

For what period and hours will the injured worker require these services?

When will you review the injured worker to reassess the need for these services?

What actions should be undertaken during the next three months to increase the injured worker's capacity to perform these tasks or to provide care for the child or children?

Who is implementing/ monitoring these actions?

TREATING PRACTITIONER'S DETAILS

Treating practitioner's name

Treating practitioner's address (Please print)

State

Postcode

Signature

Date

Rehabilitation case manager (If applicable)

Endorse

Phone number

Note:

This form should be submitted once it has been completed and signed by the injured worker, the treating doctor and rehabilitation case manager (where applicable). If the injured worker is still employed, the form should be submitted to the case manager at the injured worker's workplace. For injured workers no longer employed by an Australian or ACT government department or agency this form can be submitted direct to:

Comcare
GPO Box 9905
Canberra 2601