



Australian Government

Comcare

# APPLICATION FOR HOUSEHOLD AND/OR ATTENDANT CARE SERVICES

This form is used to collect information needed to determine the household services (including childcare) and/or attendant care services you require in accordance with the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act). This application must be signed by the employee and the treating doctor.

**Note:** If you are or will be undertaking a rehabilitation (return to work) program, please discuss how this claim for household and/or attendant care services relates to your rehabilitation with your Case Manager.

**Note:** Comcare may require an assessment to be undertaken, such as by an occupational therapist, to assist in the consideration of your application.

Here are some points to assist you to complete the form:

- > Employees must complete Part A in full.
- > If your answers do not fit in the space provided, please attach additional pages with the details including any supporting documents.
- > When you have finished answering the questions, ensure you read and sign the declaration in section 4.
- > Arrange for your treating practitioner to complete Part B in full before submitting the form to Comcare.

Comcare is authorised by the SRC Act to collect, use and disclose your personal information. If Comcare is unable to collect, use and disclose your personal information for the purposes of assessing your claim or related functions, we may not be able to determine your claim. Comcare collects an employee's personal information that is reasonably required in order to manage the compensation claim, any associated rehabilitation or Comcare's regulatory requirements under the SRC Act and the *Work Health and Safety Act 2011* (WHS Act). Comcare may also need, in accordance with the *Privacy Act 1988*, to collect your personal information from, and disclose your personal information to, a number of parties, including the following:

- > your employer (including any relevant managers) when you were injured, your current employer and any subsequent employer
- > your superannuation fund manager or trustee
- > any health professional, hospitals, other health institutions, or service providers related to your claim
- > your rehabilitation case manager
- > your rehabilitation provider
- > vocational and functional assessor
- > employment agencies
- > legal advisors
- > law enforcement authorities
- > personnel engaged by Comcare to conduct research related activities
- > the Safety, Rehabilitation and Compensation Commission
- > Department of Veterans' Affairs
- > Comcare fraud investigators
- > inspectors appointed under section 156 of the WHS Act
- > information gathering service providers [comcare.gov.au/igs](http://comcare.gov.au/igs)
- > the Clinical Panel [comcare.gov.au/clinicalpanel](http://comcare.gov.au/clinicalpanel)
- > any relevant third party (or insurer) considered by Comcare to have contributed to or have information relevant to the claimed injury, illness or impairment
- > any other person assisting Comcare in the performance of its functions or exercise of its powers, including contractors and consultants
- > any other entity where there is legal obligation to do so (for example, but not limited to, responding to the direction of a court to produce documentation).

For a copy of our Privacy Policy, to request a change of your personal information or to make a privacy complaint please refer to [comcare.gov.au/privacy](http://comcare.gov.au/privacy). You can also contact us on 1300 366 979 or email us at [privacy@comcare.gov.au](mailto:privacy@comcare.gov.au).

# PART A—TO BE COMPLETED BY THE EMPLOYEE

## 1. Employee’s details

Your Comcare claim reference number  /

Your full name

Family name

Given name(s)

Your residential address

State  Postcode

Phone contact details

Home phone number (  )  Work phone number

Mobile phone number (  )  Preferred email

## 2. Details of household

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

Do you have anyone living with you?  No If no, go to 3 below  
 Yes If yes, please provide the following details.

Who are the people living with you and what are their ages, occupations and the total hours per week they are engaged in activities? Please complete the table below for each member of your household.

Name and relationship	Age	Occupation	Total hours per week engaged in activities (specify work, education and scheduled recreational activities)

## 3. What household (including childcare) or attendant care tasks do you require assistance with due to your accepted condition?

Specific task	Who performed task prior to injury?	How often?	How long does the task take?

Are you, or other members of your household, currently receiving household (including childcare) or attendant care services?

- No If no, go to 4 below
- Yes If yes, please provide the following details.

Please specify the current services and hours being provided and how they are being funded?

What is the full business name of the provider of these services (if applicable)?

Business contact number

(     )

## 4. 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

/   /

## **PART B—TO BE COMPLETED BY THE EMPLOYEE’S TREATING DOCTOR**

### **5. Endorsement by Treating Doctor**

Is the employee experiencing difficulty performing the tasks mentioned in section 3 above as a result of their work related injury?

If yes, please describe the employee’s physical limitations related their work related injury impacting their ability to perform the tasks, and their current endurance performing the tasks?

In what timeframes do you expect the employee's need for services to reduce and cease as they recover?  
Please explain why?

Are there any factors unrelated to the employee's work related injury impacting their ability to perform the tasks?

## 6. Treating doctor's details

Treating doctor's name

Contact number

Address

State

Postcode

Signature

Date

/ /

This form should be submitted to Comcare once it has been completed and signed by the injured worker and treating doctor by emailing it to [general.enquiries@comcare.gov.au](mailto:general.enquiries@comcare.gov.au), faxing it to 1300 196 971 or posting it to:

Comcare  
GPO Box 9905  
Canberra 2601