IMPORTANT

Australian Government
Department of Veterans' Affairs

Application for Attendant Allowance

Attendant allowance

The Department of Veterans' Affairs (DVA) recognises and supports the need for veterans to receive assistance with activities of daily living.

Attendant allowance is an allowance paid to a veteran suffering a severe accepted disability to assist in meeting the costs of an attendant to help the veteran with such things as dressing, feeding, washing and moving about. There are 2 rates of payment - a high rate or a low rate depending on the extent of the veteran's handicap.

The attendant may be the veteran's partner.

NOTE: The allowance is not payable if the attendant receives a carer payment (formerly Carer's Pension) from Centrelink. However, a carer allowance (formerly Domiciliary Nursing Care Benefit) does not prevent payment of the attendant allowance. The allowance is also not payable if you are being cared for in a hospital or institution and do not make any patient contribution towards your stay.

Assistance from ex-service organisations

You are encouraged to seek the assistance of an ex-service organisation of your choice in lodging this application.

Contact telephone numbers for these organisations can be found in local telephone directories or by contacting DVA in your State.

Assistance from DVA

DVA staff can also help to complete this form.

Completing this form

This form is in 3 parts and asks for details about:

PART A - your nominated representative, if any; such as name and contact details.

PART B - your disability and the level of assistance you need; to be completed by the veteran.

PART C - any brain or spinal type injury or disease; to be completed by a Medical Officer. If you are applying on the basis of an amputation or blindness in both eyes, **no medical report is required**.

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Read more: How DVA manages personal information

Giving false or misleading information is a serious offence.

If any details you give on this form change, you must tell the Department within 21 days.

For information, please call the Department of Veterans' Affairs (from anywhere in Australia) on: **133 254**

Callers from regional Australia can call: **1800 555 254**

State	Address	Postal address
New South Wales	Centennial Plaza Tower B 280 Elizabeth Street Sydney NSW	GPO Box 9998 Sydney NSW 2001
Victoria	300 Latrobe Street Melbourne VIC	GPO Box 9998 Melbourne VIC 3001
Queensland	Bank of Queensland Centre 259 Queen Street Brisbane QLD	GPO Box 9998 Brisbane QLD 4001
South Australia	Blackburn House 199 Grenfell Street Adelaide SA	GPO Box 9998 Adelaide SA 5001
Western Australia	AMP Building 140 St Georges Terrace Perth WA	GPO Box 9998 Perth WA 6848
Tasmania	Barrack Place 254 - 286 Liverpool Street Hobart TAS	GPO Box 9998 Hobart TAS 7001
Northern Territory	Civic Plaza Building 2 Chung Wah Terrace Palmerston NT	GPO Box 9998 Darwin NT 0801
Australian Capital Territory	Cnr Moore & Rudd Streets Canberra ACT	GPO Box 9998 Canberra ACT 2601

PART A Representative's details

To be completed only if you wish to nominate a representative to act for you in matters relating to this application

1 Do you wish to nominate a representative or organisation to act for you in matters relating to this application?

No ☐ ▶ Go to **Question 3**

Yes ☐ ▶ Full name of nominated representative

Organisation *(if applicable)*

Address

POSTCODE

Telephone

Home ( )

Work ( )

Facsimile ( )

E-mail address

2 Is the representative trained under the Training and Information Program (TIP)?

No ☐

Yes ☐ ▶ To what level?

PART B Veteran's details

To be completed by the veteran

3 DVA file number *(if known)*

4 Your surname

5 Your given names

6 Postal address

POSTCODE

7 Telephone number(s)

Home ( )

Work ( )

Mobile

Facsimile ( )

E-mail address

8 Which category *best* describes your accepted disability?
(Please tick one box)

A	Blindness in both eyes	☐ ▶ Go to **Question 11**
B	Blindness in both eyes together with total loss of speech or total deafness	☐ ▶ Go to **Question 11**
C	Amputation of both arms	☐ ▶ Go to **Question 11**
D	Amputation of both legs and one arm	☐ ▶ Go to **Question 11**
E	Amputation of both legs at the hip	☐ ▶ Go to **Question 11**
F	Amputation of one leg at the hip and the other leg amputated in the upper third	☐ ▶ Go to **Question 11**
G	A leg, foot, hand or arm that has been rendered permanently and wholly useless	☐ ▶ Go to **Question 11**
H	A disease or injury affecting the brain and spinal cord system	☐ ▶ Go to **Question 9**
I	A disease or injury similar in its effect or severity to one affecting the brain and spinal cord system (such as a disease affecting the spine itself)	☐ ▶ Go to **Question 9**

9 What is the accepted disability (or disabilities) that affects your ability to care for yourself?

10 Describe the level of assistance you need with the normal requirements of living, such as moving about, walking, dressing, personal grooming, washing and bathing, feeding, or moving around in bed.

11 Are you being cared for in a hospital or other institution?

No ☐
Yes ☐ ▶ Are you paying contribution towards your care?
No ☐ Yes ☐

12 Is your attendant in receipt of a carer payment from Centrelink? (A carer allowance is a different payment and details of this allowance are **not** required)

No ☐
Yes ☐ ▶ Type of benefit

Date of claim
/ /

Reference number

13 Has your attendant applied for a carer payment from Centrelink?

No ☐
Yes ☐

14 Please provide details of your attendant, if other than your partner.

Attendant's full name

Address

POSTCODE

Telephone

Home ( )

Work ( )

Declaration and consent

NO REPRESENTATIVE APPOINTED

Please complete if you do not have a representative appointed in PART A.

I declare that the details I have given in this form are complete and correct.

I am aware that giving false or misleading information is a serious offence.

I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.

I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

YOUR SIGNATURE

Date / /

REPRESENTATIVE APPOINTED

Please complete if you have a representative appointed in PART A.

I declare that the details I have given in this form are complete and correct.

I am aware that giving false or misleading information is a serious offence.

I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.

I authorise the nominated representative or organisation to act for me in respect of this application and any reviews in respect of this or subsequent decisions. This authorisation will continue until I:

- revoke the authorisation; or
- nominate another representaive or organisation to act for me.

I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

YOUR SIGNATURE

Date / /

PHYSICAL OR MENTAL INCAPACITY

If the veteran is unable to sign due to physical or mental incapacity, please sign on behalf of the veteran at either 'NO REPRESENTATIVE APPOINTED' or 'REPRESENTATIVE APPOINTED' above and provide the following details.

Your full name

Address

POSTCODE

Telephone

Home ( )

Work ( )

I declare that I am authorised to act on behalf of the veteran in matters relating to this application. *(Tick one box below).*

☐ I have attached a copy of the authority document or a medical certificate attesting to this incapacity.

☐ I have provided DVA with a copy of *Type of document*

Please attach a copy of the document that gives you legal authority to act on behalf of the veteran, unless this has already been provided to the Department.

YOUR SIGNATURE

Date / /

PART C Medical report

To be completed by a Medical Officer only if the veteran is claiming on the grounds of brain and spinal type injury or disease as indicated by ticking boxes **H** or **I** in **Question 8** of **PART B**.

The Department will pay you for this service according to Schedule of Fees. An account, showing the time spent in consultation, must be lodged before payment can be made.

15 Veteran's full name

16 Indicate the level of personal assistance required by the veteran for *each condition* you list.

Please use Grading Codes as shown.

Grading Codes

A	Independent, and can perform the task as well as peers do, or with minor difficulty only.
B	Can complete the task independently, but with considerably more difficulty than peers have.
C	Requires some degree of personal assistance in order to perform the task.
D	Requires extensive assistance in order to perform the task.
E	Unable to contribute towards performance of the task. Completely dependent.

Please provide:

- the medical diagnosis for each condition that contributes to the veteran requiring assistance; and
- the level of assistance needed to perform the activity by using the Grading Codes.

	Grading Code (A, B, C etc.)
Moving in bed	
Transferring	
Walking	
Dressing	
Hygiene	
Feeding	

Medical Officer's details

17 Your name (please PRINT)

18 Address

POSTCODE

19 Contact phone number

( )

20 Signature

YOUR SIGNATURE

Date

/ /

Save Print Clear