

## Cardholder Application Form

Office use only

### HOW TO APPLY

- Step 1** Read the NSW Companion Card brochure. Be sure you understand the terms and conditions of Companion Card.
- Step 2** Complete this application form using BLOCK LETTERS. Do not use a photocopy of this form.
- Step 3** Obtain two, high quality, colour passport photographs from a passport photo outlet and attach them with a clip. Do not staple glue or pin your photographs to the form.
- Step 4** Have both the application form and photographs signed by the Service Provider who signed ITEM 5 or the same Health Professional who signed ITEM 7.
- Step 5** Make sure the back page of the application is completed.
- Step 6** Return this application in the envelope provided to:

**Companion Card**  
**PO Box R160**  
**Royal Exchange NSW 1225**

- ➔ **Do not fold the application form.**
- ➔ **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.

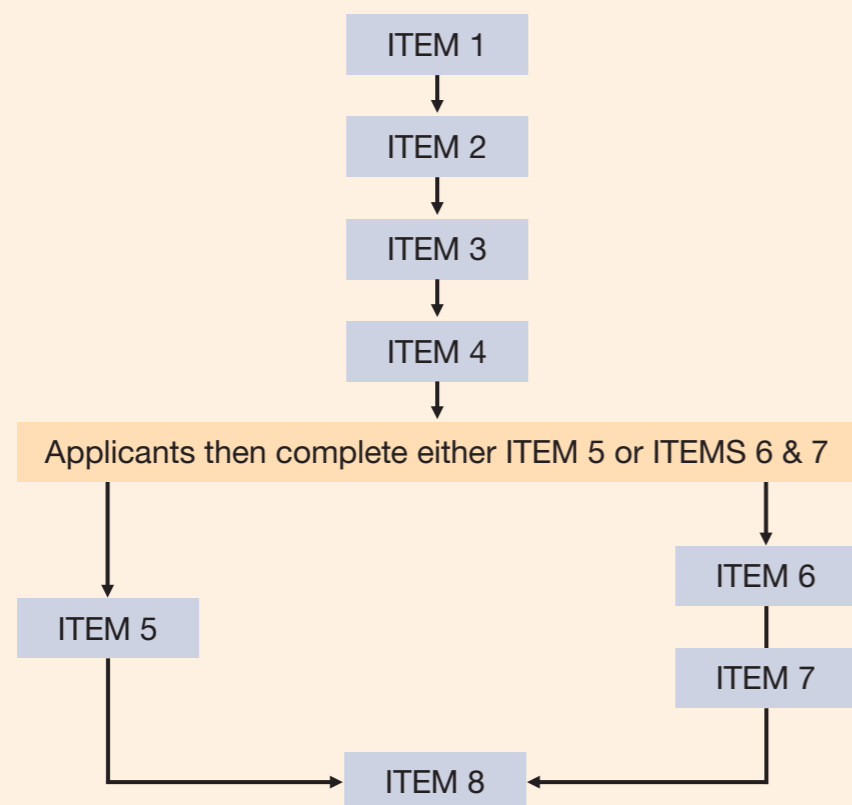
### PRIVACY

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.

## HOW TO COMPLETE THIS FORM

**All applicants** are required to complete ITEMS 1 – 6



**All applicants** are required to complete ITEM 10 & attach signed photographs

Please complete this application form in **BLOCK LETTERS** using blue or black pen.

When completing this application please place ticks in the tick-boxes provided.  
Please **DO NOT** place crosses in the boxes or circle the boxes

Correct



Incorrect



**NOTE Replacement cards are not issued using this form.**

To replace a lost, stolen or damaged card, phone 1800 000 000 to request a 'replacement/change of details' form.

## 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.

Your title  (eg. Mr/Mrs/Ms/Miss/other)

Surname

First name

Preferred name

Gender  male  female

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

Telephone number

TTY (if available)

Email (if available)

Residential address

Suburb:

State  Postcode

Postal address  (if different from above)

Suburb

State  Postcode

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

Do you identify as an Indigenous Australian?

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** Is your need for attendant care support to participate at community venues and activities permanent (i.e. lifelong)?

Yes  No If your need for attendant care support is not permanent, you are not eligible to receive a Companion Card.

**ITEM 4** Please tick the boxes and describe your disability. We have provided some examples of diagnoses or conditions to assist you to complete ITEM 4.

(You can tick more than one box)

- Physical (e.g: muscular dystrophy, quadriplegia, cerebral palsy)  
Diagnosis
- Neurological (e.g: Alzheimer's disease, Huntington's disease)  
Diagnosis
- Sensory (e.g: deafblind, legally blind)  
Diagnosis
- Acquired Brain Injury (e.g: stroke, head injury)  
Diagnosis
- Intellectual (eg: Down Syndrome, Rhetts 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.


Is your condition is episodic?  Yes  No

Describe the frequency of the episodes  times a month

Provide the date of your diagnosis  /  /

**ITEM 5** Services and supports

Do you currently receive (or have approval to receive) one of the specific services or supports listed below?

No > proceed to **ITEM 6** to continue with your application.

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

- DADHC operated group home
- Attendant Care Funding
- DADHC Operated Large Residence
- NGO Large Residence
- Australian Government's Funded High Level Residential Aged Care service
- Australian Government's Funded Extended Aged Care at Home Package
- Australian Government Department of Veteran's Affairs Attendant Allowance
- Non Government Organisation Community Living (group home)
- High Needs Pool Funding
- Australian Government's Funded Community Aged Care Package.

Section 1

Section 2

**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

Telephone number

Email

**ITEM 5** (continued)

**Declaration**

I confirm that my signature below verifies ALL of 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

Organisation stamp (if available)

If you have completed ITEM 5, please proceed to ITEM 8  
(do not complete ITEM 6 and 7)

**ITEM 6** To be completed by you or by the person assisting you to complete this form.

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.

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)


How do you currently participate at community venues and activities?


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

	never	partly*	completely**	Further details (optional)
Personal care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Remembering things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Understand or follow instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
My health care i.e. breathing, taking medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moving around, standing, walking, and carrying things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Getting to places out of walking distance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

\* partly - can do but need assistance to complete  
 \*\* completely - 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 score, CARS score, etc)


### ITEM 7 Health Professional Declaration

If you have completed ITEM 5, you do not need to complete ITEM 7.

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

- Registered medical practitioner
- Registered nurse
- Registered physiotherapist
- Registered psychologist
- Qualified occupational therapist eligible for membership in Occupational Therapy Australia
- Qualified social worker eligible for membership in Australia Association of Social Workers
- Qualified speech pathologist eligible for membership in Speech Pathology Australia

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

Please describe in detail the functional impact of the applicant's disability.


Describe the attendant care required by the applicant to enable them to participate at community venues and activities.


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


My signature below confirms all the following:

- I have read all the information contained within this form 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 signed the reverse of both photographs to verify that they are of the applicant
- 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

Telephone number

Email

Signature   
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

Date  /  /

**PROCEED TO ITEM 8**

**ITEM 8** 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 of any other disability services or disability-related payments the applicant receives.


**Statement by applicant/guardian/agent**

I confirm that my signature on the next page verifies 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 have a permanent disability and I will always require attendant care support to participate at most community venues and activities; and
- I certify that the information in this form is correct; and
- I understand and accept the Cardholder Terms and Conditions
- I understand it is an offence to provide any false information in this application.

Attach two colour passport photographs here using paper clips or fold-back clips. Do not use tape, staples, glue or pins.

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



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

**You MUST provide one of the following signatures:**

For applicants **over 18** years of age

Applicant signature  Date

**OR**

For applicants **under 18** years of age, or if unable to sign

Legal guardian/agent signature  Date

Name of legal guardian/agent

Relationship to applicant

Telephone/ TTY (   )

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

**Person who completed this form** (if different from above)

Name

Relationship to applicant

Telephone/ TTY (   )

For further information or assistance please visit [www.companioncard.org.au](http://www.companioncard.org.au) or telephone Companion Card NSW on **1800 893 044**