Australian Government
Department of Human Services

centrelink

Work capacity — Customer Information

Who should complete this form?

This form should be completed by a person with a disability, illness or injury who is looking for work and is applying for a Centrelink payment or claiming a pension from another country.

Please return the completed form **within 28 days** of receiving it, to ensure that you get assistance from the earliest date possible.

1 Customer details

Centrelink Reference Number (if known) ___ – ___ – ___ – ___

Family name

Maiden name (if applicable)

Previous married name (if applicable)

Other aliases (if applicable)

Given name(s)

Date of birth Day / Month / Year

Male ☐ Female ☐

Address

Postcode

Is there a telephone number we can contact you on?

No ☐

Yes ☐ ( )

Do you need an interpreter?

No ☐

Yes ☐ Preferred language

2 Please list any disabilities, illnesses or injuries that you have

CLK0AUS142 1402

3 When did these disabilities, illnesses or injuries start to make it difficult for you to work or study full-time?

Month / Year /

OR I have had my disabilities or illnesses since birth ☐

4 Are you getting any treatment for your disabilities, illnesses or injuries?
e.g. medication, physical therapy, counselling

No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

5 Have you ever been hospitalised because of these disabilities, illnesses or injuries?

No ☐
Yes ☐ ▶ Date of last admission — Day / Month / Year

Name of hospital

Duration of stay — From (Day / Month / Year) To (Day / Month / Year)

Reason for admission
e.g. operation, investigation, treatment

Number of admissions in the last 5 years

6 Are you expecting to have an operation in the future?

No ☐
Yes ☐ ▶ Type of operation/procedure

Expected date (if known) — Day / Month / Year

Where will operation take place (if known)

Reason for operation

7 How often does your disability, illness or injury make it difficult for you to:

	no problem	sometimes	often	all the time	**Please give further details** (if applicable)
sit	☐	☐	☐	☐	
stand	☐	☐	☐	☐	
walk	☐	☐	☐	☐	
climb stairs	☐	☐	☐	☐	
drive a car	☐	☐	☐	☐	
use public transport	☐	☐	☐	☐	
pick up objects	☐	☐	☐	☐	
handle objects	☐	☐	☐	☐	
lift	☐	☐	☐	☐	
carry	☐	☐	☐	☐	
bend	☐	☐	☐	☐	
operate everyday appliances or machinery	☐	☐	☐	☐	
read	☐	☐	☐	☐	
write	☐	☐	☐	☐	
speak	☐	☐	☐	☐	
hear	☐	☐	☐	☐	
concentrate	☐	☐	☐	☐	
remember	☐	☐	☐	☐	
interact with others	☐	☐	☐	☐	
attend work or other appointments	☐	☐	☐	☐	
understand or follow instructions	☐	☐	☐	☐	
sleep	☐	☐	☐	☐	
breathe	☐	☐	☐	☐	
manage your personal affairs	☐	☐	☐	☐	
care for yourself*	☐	☐	☐	☐	
care for others	☐	☐	☐	☐	

* If you have someone caring for you full-time, they may be eligible for a payment for carers. *Please contact International Services if you need further details.*

8 In a workplace, would your disabilities, illnesses or injuries make it difficult for you to:

	no	sometimes	often	all the time	**Please give further details** (if applicable)
A interact with others?	☐	☐	☐	☐	
B maintain appropriate behaviour?	☐	☐	☐	☐	
C cope with work related stress or pressure?	☐	☐	☐	☐	
D learn new tasks?	☐	☐	☐	☐	
E remember how to do tasks?	☐	☐	☐	☐	
F understand and follow instructions?	☐	☐	☐	☐	
G concentrate?	☐	☐	☐	☐	
H persist at tasks without unscheduled breaks?	☐	☐	☐	☐	
I undertake more than one task?	☐	☐	☐	☐	
J look after your personal care needs?	☐	☐	☐	☐	
K physically complete tasks?	☐	☐	☐	☐	
L move safely around the workplace?	☐	☐	☐	☐	
M communicate with others?	☐	☐	☐	☐	
N control the use of your language?	☐	☐	☐	☐	

9 Who is the doctor who you usually see about your disabilities, illnesses or injuries?

e.g. your general practitioner.

Name

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

10 Have any specialists or other doctors treated you for these disabilities, illnesses or injuries?

No ☐

Yes ☐ ▶

Name

Address

Postcode

Telephone ( )

Date of last visit Day / Month / Year

Conditions for which you were treated

If you have specialist reports, please attach copies.

11 Is there anybody else you have consulted or that has assisted you with any of your disabilities, illnesses or injuries?

e.g.
- counsellor
- social worker
- community health worker
- teacher
- psychologist
- physiotherapist

No ☐

Yes ☐ ▶

1

Name

Profession

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

2

Name

Profession

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

If you need more space please attach a separate sheet of paper with details.

12 Is there any other information you feel we need to know about your disabilities, illnesses or injuries?

No ☐

Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

13 School or full-time education details

How old were you when you left school or full-time education? years old

Year of leaving school/education

What grade/year did you reach?

What is the highest educational qualification you obtained? e.g. Year 10 Certificate, Higher School Certificate, Degree

14 Have you gained any other qualifications, skills or experience?

Include things like voluntary work, courses, trade tickets, licences, diplomas, tertiary qualifications.

No ☐

Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

15 Have you ever worked?

No ☐ ▶ Go to **Question 18**

Yes ☐ ▶ What date did you last work? Month / Year

16 What were your last 2 jobs?

Your last job

Type of job

Days worked per week

Was this work: Full-time ☐ Part-time ☐ Casual ☐

Name of employer

Contact phone number ( )

Reason for leaving this job (e.g. retirement, resignation, caring for family, medical condition – specify which medical condition)

Your 2nd last job

Type of job

Days worked per week

Was this work: Full-time ☐ Part-time ☐ Casual ☐

Name of employer

Contact phone number ( )

Reason for leaving this job (e.g. retirement, resignation, caring for family, medical condition – specify which medical condition)

If you need more space please attach a separate sheet of paper with details.

17 Have you been given or offered extra support in the workplace because of your disability, illness or injury, such as modification to your environment, reduced hours of work, alternative duties, retraining etc?

No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

18 Have you participated in any programs to help you find work, stay in a job, return to work, manage your injury or help you with vocational rehabilitation, gaining new skills, work experience or training?

No ☐
Yes ☐ ▶

1 Name of provider
Type of program
Dates you participated From (Day / Month / Year) To (Day / Month / Year)

2 Name of provider
Type of program
Dates you participated From (Day / Month / Year) To (Day / Month / Year)

Attach any documentation you have which provides details of your participation in the program, including when the program started and finished, the requirements of the program, what activities you undertook while in the program and for how long.

19 Is there any reason why you could not do a rehabilitation or training program in the future?

No ☐
Yes ☐ ▶ Is this because you are about to have other treatment?
No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

Is this drug or alcohol related?
No ☐
Yes ☐

Is there another reason?
No ☐
Yes ☐ ▶ Please give details

If you need more space please attach a separate sheet of paper with details.

20 When do you think you will be able to start part-time or full-time work or study?

now ☐ within 6 months ☐ 6–12 months ☐ 12–24 months ☐ more than 2 years ☐ never ☐

21 Did someone help you complete this form?

No ☐

Yes ☐ ▶ Who helped you?

Name

Address

Postcode

Telephone ( )

Do you give permission for us to contact this person? No ☐ Yes ☐

22 IMPORTANT INFORMATION

Privacy and your personal information

Your personal information is protected by law, including the *Privacy Act 1988*, and is collected by the Australian Government Department of Human Services for the assessment and administration of payments and services. This information is required to process your application or claim.

Your information may be used by the department or given to other parties for the purposes of research, investigation or where you have agreed or it is required or authorised by law.

You can get more information about the way in which the Department of Human Services will manage your personal information, including our privacy policy at **humanservices.gov.au/privacy** or by requesting a copy from the department.

23 Your statement

If the customer cannot sign this form, it should be signed by their legal representative and a copy of their guardianship or power of attorney papers should be attached.

I declare that:

- the information I have given is correct.

I understand that:

- giving false or misleading information is a serious offence.

Your signature

Date

Day / Month / Year

Return this form to:

Department of Human Services
International Services
PO Box 7809
Canberra BC ACT 2610
AUSTRALIA

1 Check that you have read and signed your statement above.

2 Attach any further information you feel supports your application. If you cannot provide all of the documents immediately, do not delay returning your form. Please supply any remaining documents as soon as possible to Department of Human Services, International Services, PO Box 7809, Canberra BC ACT 2610, AUSTRALIA.

NOTE: If you are in New Zealand, lodge this completed form with Work and Income in New Zealand.

ENQUIRIES

If you have any questions please call

(+61 3) 6222 3455 (outside Australia)

131 673 (inside Australia)

Note: Call charges apply – calls from mobile phones may be charged at a higher rate.