Instructions Print Clear

Australian Government
Department of Human Services

centrelink

# Information about participation in a program of support

**Customer's details**

Full name

Address

Postcode

Date of birth / /

Phone number ( )

Centrelink Reference Number – – –

**Person issuing this form**

Full name

Address

Postcode

Date of issue / /

## Information for the Customer

This information is needed by the Australian Government Department of Human Services to assess eligibility for income support payments, and to make sure that correct payments are made.

**Important:** This request is a notice given under section 63 of the *Social Security (Administration) Act 1999*. If the requested information is not provided, it may affect our ability to assess your eligibility for payments.

1. **Check that your details above are complete.**

2. **Contact your program of support provider to arrange to have this form completed.**
   Make sure the Provider knows that you will need this form completed by them, **within 14 days of** this form **being issued**.

3. **When the Provider has completed this form, it must be returned to the Department of Human Services.**
   The Provider can give this form to you, or they can return it directly to us.

## Information for the Provider

This customer has applied for an income support payment and one of the legislated requirements is that this customer needs to demonstrate they have actively participated in a program of support. This customer has indicated they have done such a program. The information provided in this form will assist in assessing this customer's eligibility for an income support payment.

### What is a program of support?

A program of support is a program that:

- is specifically tailored to address the person's level of impairment, individual needs and barriers to employment, **and**
- provides vocational, rehabilitation or employment activities with a particular focus on developing skills the person requires to improve the person's capacity to find, gain and remain in employment.

### Completing this form

In this form you will be asked to provide details of the program of support for this customer, named above. Please complete all the required questions in this form.

This form needs to be completed **within 14 days** of it being issued, to make sure income support payments made to this customer are correct.

If you require another copy of this form, go to our website at **humanservices.gov.au/forms**

### Returning this form

You can give this form and any attachments to this customer or you can return it to **Department of Human Services, Disability Services, Reply Paid 7806, CANBERRA BC ACT 2610**.

**Thank you for your assistance.**

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**1** In the last 3 years have you provided a program of support (see definition on page 1) to this customer?

No ☐ ▶ ***Go to 18***

Yes ☐ ▶ If you provided more than one program for this customer, you will need to copy and complete pages 2–4 of this form for each program.

▶ *Go to next question*

**2** What is the name of the program you provided for this customer?

**3** Please describe the purpose and scope of the program

**4** Date this customer started the program

/ /

**5** Is this customer still in the program?

No ☐ ▶ *Go to next question*

Yes ☐ ▶ ***Go to 8***

**6** Did this customer complete the program?

No ☐ ▶ Date customer exited the program.

/ / ▶ *Go to next question*

Yes ☐ ▶ Date completed

/ / ▶ ***Go to 8***

**7** Please give the reason(s) why this customer exited without completing the program

**8** Were there any breaks in the program (i.e. periods of in-activity, non-attendance or suspension of the program)?

No ☐ ▶ *Go to next question*

Yes ☐ ▶ Give details below

Period of break

Start date / / End date / /

Reason

Period of break

Start date / / End date / /

Reason

Period of break

Start date / / End date / /

Reason

If you need more space, attach a separate sheet with details.

**9** Was/is the program specifically designed to address the circumstances of this customer?

**Include** interventions, aids and other types of assistance specifically tailored to address this customer's disability, injury or health condition and identified needs and barriers to employment.

No ☐ ▶ *Go to next question*

Yes ☐ ▶ Give details below

**10** What would they normally need to do to fulfil the objectives of the program?

Please describe any attendance or other conditions needed to meet the objectives of the program (e.g. take part in activities recommended by the provider, undergo prescribed medical or rehabilitation treatment, try a new position for a period of time etc.).

**11** How often did/does this customer attend the program?

As agreed ☐ *Go to next question*

More than agreed ☐ *Go to next question*

Less than agreed ☐ Give details below

**12** Did/does this customer comply with other program objectives?

No ☐ Give details below

Yes ☐ Give details below

**13** As part of the program, did/does this customer undertake any activities to address any disability, injury or health condition?

**Include** vocational or occupation rehabilitation, injury or pain management.

No ☐ *Go to next question*

Yes ☐ Give details below unless already provided

**14** As part of the program, did/does this customer undertake any activities to find, gain or remain in employment?

**Include** job search, job preparation, education or vocational training, work experience, support provided in the workplace.

No ☐ *Go to next question*

Yes ☐ Give details below unless already provided

**15** What outcomes were/have been achieved by this customer?

**Include** employment placement(s).

**16** Has this customer been referred on to other services or programs to continue assistance?

No ☐ *Go to next question*

Yes ☐ Give details below

**17** **Please read this before answering the following questions.**

All the information contained in, or attached to, this form may be subject to release under the *Freedom of Information Act 1982* (the FOI Act) and/or during any appeal processes concerning decisions made about the individual to any person(s) (including those named in either this form or its attachments). If you want any of this information treated in confidence, please include a statement outlining your concerns. This will then be considered if a request is made under the FOI Act.

Is there any information in this form which, if released to this customer, might be prejudicial to his/her physical or mental health?

No ☐ ▶ *Go to next question*

Yes ☐ ▶ Identify the information and state why it should not be released directly to the customer.

When all details have been completed, please return this report directly to the address identified on page 1.

If you need more space, attach a separate sheet with details.

**18** Do you wish to discuss this form with us?

No ☐

Yes ☐

**19**

**Confidentiality of information** The personal information that is provided to you for the purpose of this form must be kept confidential under section 202 of the *Social Security (Administration) Act 1999*. It cannot be disclosed to anyone else unless authorised by law. There are penalties for offences against section 202 of the *Social Security (Administration) Act 1999*.

**20** **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.

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.

**21** Details of the program provider

Please print in BLOCK LETTERS.

Name of the service provider or organisation

Address

Postcode

Name of contact

Contact phone number

( )

Email

@

Name of case worker (if applicable)

Signature

Name of person signing

Date

/ /

## Returning this form

**You can give this form and any attachments to this customer or you can return it to us. However, if you answered 'Yes' at question 17, please make sure to return this form directly to:**

**Department of Human Services**
**Disability Services**
**Reply Paid 7806**
**CANBERRA BC ACT 2610.**