Disability Allowance application

MINISTRY OF SOCIAL DEVELOPMENT
TE MANATŪ WHAKAHIATO ORA

The Disability Allowance helps with extra costs if you or a family member has a health condition, injury or disability lasting more than six months. The allowance can help with extra costs directly related to the health condition, injury or disability.

You'll need your doctor, specialist or nurse practitioner to fill in the Disability Allowance medical certificate in this form. You need to complete a separate form for each person you're applying for, so please ask if you need more forms.

Write your client number here if you know it. This number can be found on your Community Services Card or SuperGold Card if you have one.

Client number | | | | | | | | | |

Tell us your details

1 What is your full name?

First and middle names

Surname or family name

2 What date were you born?

Day Month Year

3 Where do you live?

HOW TO ANSWER Q3:
If you live in a rural area, flat/house number could include your RAPID number, fire number, emergency services number.

Flat/House number

Street name

Suburb

Town/City

4 Is your mailing address different from where you live?

HOW TO ANSWER Q4:
Mailing address can include a PO Box, rural delivery details, or C/O address.

☐ No ☐ Yes **If yes, tell us your mailing address**

5 How else can we contact you?

HOW TO ANSWER Q5:
Please only give us contact details you'd like us to use.

		Tick the best way for us to first contact you
Home phone	( )	
Mobile phone	( )	
Other phone	( )	
Email		

Te ll us about your relationship status

6 Do you have a partner?

☐ No **Go to question 9** ☐ Yes

7 What is your partner's full name?

First and middle names

Surname or family name

8 What is your partner's date of birth?

Day Month Year

Tell us about your income and assets

Tell us about income in the last 52 weeks?

9

ATTACHMENT FOR Q9:
Bring a copy of your business accounts.

INFORMATION FOR Q9:
In this application form, 'partner' means the person you're married to or in a civil union or relationship with, not a business partner.

Did you or your partner (if you have one) get income from any of the following sources in the last 52 weeks?

Wages or salary	☐ No	☐ Yes	
Termination pay	☐ No	☐ Yes	
Redundancy pay	☐ No	☐ Yes	
Accident compensation (eg ACC)	☐ No	☐ Yes	
Income insurance (replacement/protection)	☐ No	☐ Yes	☐ Jointly with partner
Farm or business income	☐ No	☐ Yes	☐ Jointly with partner
Payments from self-employment or contract work	☐ No	☐ Yes	☐ Jointly with partner
Interest from savings, investments, or bonds	☐ No	☐ Yes	☐ Jointly with partner
Dividends from shares, unit trusts, or managed funds	☐ No	☐ Yes	☐ Jointly with partner
Income from rents	☐ No	☐ Yes	☐ Jointly with partner
Payments from boarders or flatmates	☐ No	☐ Yes	☐ Jointly with partner
Child Support payments (private arrangement or through Inland Revenue)	☐ No	☐ Yes	
Other income for a child	☐ No	☐ Yes	
Maintenance payments	☐ No	☐ Yes	
Payments from a former partner	☐ No	☐ Yes	
Student Allowance, scholarship, or Student Loan living cost payments	☐ No	☐ Yes	
Overseas pension, benefit or allowance payments	☐ No	☐ Yes	
Other superannuation or retirement scheme income (government or private)	☐ No	☐ Yes	
Income from an estate, if you've inherited money	☐ No	☐ Yes	☐ Jointly with partner
Income from trusts	☐ No	☐ Yes	☐ Jointly with partner
Other	☐ No	☐ Yes	☐ Jointly with partner

ATTACHMENT FOR Q10:
You need to show us proof of income.

10

Did you answer 'yes' or 'jointly with partner' to any of the sources of income listed in question 9?

☐ No ☐ Yes **If yes, tell us the total before-tax amounts, for the last 52 weeks**

Where did the payment come from?	You	Your partner	Jointly with partner
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$

HOW TO ANSWER Q11:
The types of income you need to include here are listed in question 10.

11 **Do you or your partner (if you have one) expect to get income or other payments in the next 52 weeks?**

☐ No ☐ Yes **If yes, write the details below. Tell us the before-tax amounts**

Where will the payment come from?	You	Your partner	Jointly with partner
	$	$	$
	$	$	$
	$	$	$

Tell us about the person you're applying for

ATTACHMENT FOR Q12:
You need to provide a Disability Allowance medical certificate for each person you apply for.

INFORMATION FOR Q12:
You may be able to get a Child Disability Allowance for the same child. Please ask us.

12 **Who in your family has health-related costs?**

☐ You ☐ Your partner ☐ Your dependent child

If applying for your dependent child, tell us their names

Child's first name	Child's surname

Tell us about any payments you get for these health needs

13 **Do you get payments from private medical insurance for any health-related needs?**

☐ No ☐ Yes **If yes, please write the details below**

What cost is covered	How much is paid?	Name of person the payment is for
	$	
	$	
	$	

14 **Is this health condition covered by ACC or War Disablement Pension?**

☐ No ☐ Yes If 'yes', you may not be entitled to a Disability Allowance

Describe your extra costs

HOW TO ANSWER Q15:
Extra costs must be directly related to the health condition. Costs can include medical and prescription costs, medical alarms, lawn mowing, extra power or gas, transport and special equipment.

ATTACHMENT FOR Q15:
You'll need to show proof of these costs.

15 **What extra health-related costs do you have?**

Type of cost	Cost	How often? (For example weekly, monthly, yearly)	Name of person costs relate to
	$		
	$		
	$		
	$		
	$		
	$		
	$		
	$		

Obligations and signature

Let us know when things change

You need to let us know about changes that might affect the amount you're paid, like:

- starting, stopping or changing jobs
- starting or finishing part-time or full-time study
- changes to your pay or other income, including getting an overseas pension
- starting to run a business (for yourself or someone else).

Changes to information about you or your family, like:

- name, address, contact details or bank account number
- starting or ending a relationship, marriage, or civil union
- a partner passes away
- the number of children in your care, including having another baby.

We also need to know if you:

- are travelling overseas
- go into or come out of hospital
- are being held in custody or on remand.

Your rights

If you don't think we have things right or there's something you don't understand:

- call us – we can usually fix it over the phone
- you have the right to ask us to review the decision. Find out how at **msd.govt.nz/reviews**

Signature

- I've answered all the questions that apply to me and my situation
- I understand the changes I need to let you know about
- The information I've given you is true and complete.

Applicant's name (print)	Applicant's signature	Day	Month	Year

Applicant's partner's name (print)	Applicant's partner's signature	Day	Month	Year

Disability Allowance medical certificate

Health practitioner to complete

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The Disability Allowance is available for reimbursement of additional costs arising from a disability where the following criteria are met:

1. The person has a disability which is likely to continue for at least six months; and
2. The disability has resulted in a reduction of the person's independent function to the extent that:
   - the person requires ongoing support to undertake the normal functions of life, or
   - the person requires ongoing supervision or treatment by a health practitioner.

For the purposes of qualifying for Disability Allowance, a disability means:

- physical disability or impairment
- physical illness
- psychiatric illness
- intellectual or psychological disability or impairment
- any other loss or abnormality of psychological, physiological, or anatomical structure or function (including sensory impairment)
- reliance on a guide dog, wheelchair, or other remedial means
- the presence in the body of organisms capable of causing illness.

The information you provide below is covered by our Privacy Statement which lets clients know we may contact health providers to check the health-related information they give us.

For more information go to **workandincome.govt.nz** and search *Disability Allowance*.

Client details

1 **Client number** ☐☐☐ | ☐☐☐ | ☐☐☐

2 **Client's name**

First names _____ Surname _____

Disability details

3 **Does the person have a disability that meets the Disability Allowance criteria?**

☐ Yes → **If yes, provide the details below**

☐ No → **Go to Health Practitioner Verification**

4 **What is the nature of the person's disability?** → **Please tick the major disabilities or specify below**

Psychological or psychiatric conditions
- ☐ Stress (160)
- ☐ Depression (161)
- ☐ Bipolar disorder (162)
- ☐ Schizophrenia (163)
- ☐ Other psychological/psychiatric (165)

Nervous system disorders
- ☐ Epilepsy (120)
- ☐ Multiple sclerosis (121)
- ☐ Parkinson's disease (122)
- ☐ Muscular dystrophy (123)
- ☐ Other nervous system disorders (124)

Cardio-vascular disorders
- ☐ Heart disease (130)
- ☐ Stroke (131)
- ☐ Other cardio-vascular (132)

Immune system disorders
- ☐ HIV / Aids (140)
- ☐ Other immune system disorders (141)

Metabolic and endocrine disorders
- ☐ Diabetes (150)
- ☐ Other metabolic or endocrine disorders (151)

Substance abuse
- ☐ Alcohol (170)
- ☐ Drug (171)
- ☐ Other substance abuse (172)

Sensory disorders
- ☐ Blindness (180)
- ☐ Other visual / eye (181)
- ☐ Hearing / ear (182)
- ☐ Other sensory disorders (183)

Accident

- ☐ Burns (190)
- ☐ Fractures, dislocations, soft tissue injury (191)
- ☐ Poisoning, toxic effects (192)
- ☐ Internal injuries (193)
- ☐ Injury to the nervous system (194)
- ☐ Back pain / injury (195)
- ☐ Overuse injury [RSI] (196)
- ☐ Complications of medical or surgical care (197)
- ☐ Other injury (198)

Other disorders

- ☐ Congenital conditions (103)
- ☐ Intellectual disability (164)
- ☐ Cancer (104)
- ☐ Infectious / parasitic diseases (105)
- ☐ Musculo-skeletal system disorder (106)
- ☐ Respiratory disorders (107)
- ☐ Genito-urinary disorders (108)
- ☐ Blood and blood forming organs (109)
- ☐ Skin disorders (110)
- ☐ Digestive system disorder (111)

5 **Please indicate the expected duration of the disability:**

☐ Less than 6 months **There may be no entitlement to Disability Allowance**

☐ 6 to 12 months ☐ 1 to 2 years ☐ 2 to 3 years ☐ Permanent (never reassess)

Verification of doctor, specialist or nurse practitioner visits

6 **Please list the type, cost and how often visits to doctors, specialists or nurse practitioners are necessary because of the stated disability:**

Type of consultation	Cost	How often (eg daily, weekly, monthly)	Health practitioner's initials
	$		
	$		
	$		
	$		
	$		

Items, services, treatments, pharmaceuticals

7 **Please list the pharmaceuticals, items, services or treatments that are necessary and of therapeutic value for the stated disability:**

Item / service / treatment / pharmaceutical	Health practitioner's initials

Health practitioner's verification

Please print your details below.

HPI number ☐☐ | ☐☐☐☐

Health practitioner's full name

Practice name and address

Telephone number ( )

Health practitioner's signature

Day Month Year