Carer Support Registration Form

WILL BE RETURNED IF ALL PARTS ARE NOT FILLED IN

MANATŪ HAUORA
Private Bag 1942, Dunedin
Tel: 0800 281 222 Press 1

On completion of this form by a specialist or general practitioner then the answer to questions 1-7 must apply to the client (person with a personal health need).

Client Details

1. Family name of client
   First name of client
   Other names client is known by
2. Date of Birth DAY / MONTH / YEAR NHI
3. Address *(please include house number, street, suburb, town and/or city)*
4. Postal Address *(if different from above)*
5. Contact Phone Number Day ( ) Night ( )
6. Ethnicity details: *(please tick)* NZ Maori ( ) NZ European ( ) Other *(please specify)*
7. Nature of illness which requires carer support allocation *(ie, diagnosis)* defined as a condition, affecting organs or systems of the body, which causes prolonged ill health

Has this client been referred for specialist review? Y / N

Has the client ever been admitted to hospital for this condition? Y / N

Please confirm that carer support is required for a personal health need only

Details of Medical Assessment

(to be completed by the doctor, please print clearly)

Doctor's Name

Organisation

Postal Address

Contact Phone Number Day ( )

Full Time Carer Details

1. Family name of full time carer
2. First name of full time carer
3. Address
4. Date of Birth DAY / MONTH / YEAR NHI

DECLARATION

By my signature I confirm that
(i) To the best of my knowledge the information contained on this form is true and correct and
(ii) I have read the "Carer Support – Eligibility" section overleaf and the client meets the eligibility requirements

I certify that *(name of person with personal health needs as above)*

Requires carer support for (number of days up to 28 days) days for one year from this date: DAY / MONTH / YEAR

Signature of doctor

To be signed by a person over the age of 16 years, or by a representative completing the form on the client's behalf. *(ie, full time carer)*
I have read and understood the statement overleaf and declare that the information I have given is true and complete.
I consent to the information being used as described overleaf.

Signature Date DAY / MONTH / YEAR

(signature of person with personal health need or representative)

MINISTRY OF HEALTH
GENERAL PRACTITIONER
CLIENT

Carer Support – Eligibility

(1) A person is eligible to access Carer Support if their personal health need is likely to continue for a minimum of six months and result in a reduction of independent function to the extent that ongoing support is required. Ongoing support means that without Carer Support there would be a significant change in the client's living circumstances.

(2) Carer Support is a service for providing relief to the full-time unpaid carer of a person with an ongoing personal health need. The person with a personal health need must require full-time care and attention.

(3) To be eligible to receive Carer Support a person must be assessed by a doctor as meeting both points 1 and 2 above.

NOTE: Application forms for payment will be posted to you upon receipt of this registration form.

Statement

Under the terms of the Privacy Act 1993 we are required to inform you of the following:
The collection of statistical information such as gender, ethnicity, and disability type will help the Ministry of Health develop a clearer picture of the requirements for people with disabilities and will ensure that future access to Disability Support Services is fair and equitable for all.
The information provided will be used:

- to ensure that the client receives the correct entitlement;
- to assist the Ministry of Health in planning and purchasing future services;
- for such other functions as permitted under law;
- to allocate you a personal identification number.

The information will also be provided to the Ministry to update the National Health Index.
All information will be forwarded to and stored with the Ministry of Health. Your service provider will also provide the Ministry of Health with information about the services you receive from them. You have the right of access to the information held about yourself and you have the right to have corrections made to this information.
You can access this information by contacting your nearest MoH office.
Ministry of Health acknowledges that under the Health Information Privacy Code (1994) all information will be received in the strictest confidence.

To be signed by a person over the age of sixteen years, or by a representative completing the form on the client's behalf. I have read and understood the above statement and declare that the information I have given is true and complete. I consent to the information being used as described above.