Australian Government

Department of Veterans' Affairs

DVA Policy

Client Benefits' Division

Compensation Claims Communication Standards

Contents

Version Control

Date of Change	Summary of Changes	Reason	Approved by
V1.1 - July 2023	New Policy – to replace Open Door Policy 2013	To outline the expected frequency and mode of contact DVA expects its staff to have with clients during the DVA compensation claims process.	Deputy Secretary, Enabling & Commemorations Group
V1.2 - October 2023	Updates to Related Policies and Procedural guidance links	To include links to the 'Our Commitment to You' webpage and where to access claim delay talking points as recommended by the Commonwealth Ombudsman	First Assistant Secretary, Claims Process Improvement Division

Introduction:

Purpose

The purpose of this instruction is to provide advice around the expected communication standards for staff in the Client Benefits Division (CBD), to help guide client expectations and to deliver minimum client service standards during the claim process.

DVA recognises that some claimants may experience feelings of uncertainty during a claim for compensation. Regular communication throughout the claims process can alleviate a significant amount of concern and worry, and help to improve their DVA experience.

The CBD Communication Standards outline the frequency and mode of contact staff are expected to have with veterans during the compensation claims process. The policy applies across all Acts and claim types and includes:

- **The frequency and mode of contact veterans can expect from the Department during the compensation claims process,**
- **Information and expectations regarding the 28 Day Reminder letters, Needs Assessment process, and Pre-Determination Calls.**
- **Links to related policies and procedural guidance**

Application

This policy applies to all CBD staff who process compensation claims.

Commitment

A review of this policy will be conducted in mid-2024.

Summary of Key Contact Points

Key Contact Points	Timeframe	Reason
Claim Acknowledgment Letter	No later than 5 working days from registration	Acknowledging receipt of claim
Claim Administration (Initial liability only)	30 day intervals	To inform clients that their claims is still in queue, and/or request additional information to support their claim
Preliminary phone call	No later than 14 days after allocation	Introductory phone call to client to set expectations of the claims process
Claim progress updates	30 day intervals, unless by exception	To provide an update on the progress of the claim investigation
Pre-Determination Call	Prior to claim completion	To inform clients that a determination is about to made, the likely outcome and the reasons for the decision
28 Day reminder letter	As required	A final reminder to request information a client may be able to provide to finalise a claim
Needs Assessment	Conducted following finalisation of an initial liability claim	To establish the needs of the veteran and identify benefits and services available

Frequency & Mode of Contact during the Claims Process

Claim Acknowledgment Letter

Upon registration, all claims must be acknowledged in writing (no later than 5 working days), using the Acknowledgement of Claims letter template generated in ISH.

Staff can refer to CLIK guidelines for information that is required in acknowledgement letters to ensure communication with veterans is both appropriate and consistent.
1.1 Holding bays and acknowledgement | Compensation claims procedures, Pre-claim procedures (dva.gov.au)

Claim Administration

Where an Initial Liability claim cannot be allocated for investigation within a reasonable timeframe, contact will be made to claimants at 30 day intervals until their claim is allocated.

Multiple modes of communication including SMS, email or letter can be used at 30, 60 and 90 days to inform clients that their claim is still in the queue, or to request additional information to support their claim.

Claim Investigation

Preliminary Phone Call

A preliminary phone call should be made to the claimant as soon as practical following the allocation of the claim to a claim support officer or delegate, and no later than 14 days after allocation.
In cases where telephone contact is unsuccessful, it is recommended that staff send an SMS call back request and include their contact details.

The preliminary phone call provides an opportunity for a staff to:

- Request additional information required to process a claim,
- Inform veterans of the key milestones in the claim investigation process and to set expectations around processing timeframes or potential delays,
- Check to see if there have been changes any circumstances that may impact on claim priority since claim lodgement, and
- Obtain advice from the claimant as to the frequency and mode of contact regarding the claim that will best suits their needs.

For consistent messaging around the key milestones in the claims process please see:
What to expect after you have submitted a compensation claim | Department of Veterans' Affairs (dva.gov.au)

Following the preliminary phone call, staff should send a follow-up email confirming what was discussed.

Claim Progress Updates

A claimant and/or their advocate or representative is to be contacted every 30 days regarding the progress of their claim unless by agreement or at the request of the claimant (to be recorded in the claim contact notes). This contact can be made by SMS, email or telephone.

Progress updates may include:

- Reminders of requests for information needed to process a claim,
- provide details of any outstanding matters such as potential delays to medical reports,
- confirm upcoming medical appointments in respect to a claim, and
- respond to any questions a client may have about their claim.

Many staff already make routine contact with veterans throughout the claims process and understand the benefits of regular communication. To ensure that the individual needs of each veteran is being taken into account, staff should maintain discretion, and exercise sound judgement where regular contact is being made.

Some examples of where monthly contact may not be required are:

- Where the claim is awaiting a medical appointment and the claimant agrees contact will be made after the appointment takes place or the report is received.
- The claimant specifically requests to be contacted less frequently.

Specific contact requirements for Case Coordinated clients should be discussed with the Case Coordinator and recorded on the claim.

Pre-Determination Call

To ensure procedural fairness where an adverse decision is being made, DVA must provide clients with a reasonable opportunity to comment on a medical report or provide additional information to support their claim. This opportunity must be provided before the claim is determined.

A pre-determination call provides staff the opportunity to inform a veteran that a determination is about to be made, the likely outcome of the determination, and explain the reasons for the decision, in a much more effective and supportive way than a determination letter.

For further information see:
3.2 Natural Justice Considerations and Prior Warning of Adverse Decisions | Military Compensation
SRCA Manuals and Resources Library, Liability Handbook, Ch 3 Determinations of Liability (dva.gov.au)

28 Day Reminder Letter

Throughout the claims process, staff may need to request additional documentation to support the investigation of a claim that only the client can provide. For example, claimant reports, contention information and witness statements. Where an information request has not been completed, staff can utilise any of the listed contact points to remind a claimant of the required information to finalise their claim. These reminders can be conducted through the use of SMS, telephone or email.

If numerous attempts to obtain the information fails and where the requested information could be provided by the client without unreasonable expense or inconvenience, staff may issue a final reminder in line with the 28 day reminder letter.

Needs Assessment

A Needs Assessment must be conducted following the finalisation of an initial liability claim, to establish the needs of the veteran and to identify benefits and services available including Incapacity Payments, Permanent Impairment, and Rehabilitation & Household Services. The Needs Assessment where possible should be conducted by phone call.

Engaging directly with the client assists DVA to have a meaningful discussion about their needs and to identify services that will support their wellbeing. The needs assessment process recognises that a veterans' needs can change along the course of the claims journey and that personal contact provides the best opportunity for these changes to be identified and acted upon.

Related Policies & Procedural Guidance

Client Communication Procedures:
Client communication procedures | Compensation claims procedures, Communication procedures (dva.gov.au)

Communicating with Representatives:
Client representation and withdrawal of consent | Compensation claims procedures, Foundations, Client representation (dva.gov.au)

Coordinated Client Support and T&C
8. Engaging with Coordinated Client Support and T&C | Compensation claims procedures, Communication procedures (dva.gov.au)

SMS
SMS | Compensation claims procedures, Communication procedures (dva.gov.au)

Written communication & signature blocks:
Written communication | Compensation claims procedures, Communication procedures (dva.gov.au)

Our commitment to you:
Our commitment to you | Department of Veterans' Affairs (dva.gov.au)

For internal use only: DVA staff can access monthly claim delay talking points and further support on how to identify and handle at risk clients via the Veteran Access Network's intranet site.

Australian Government

Department of Veterans' Affairs

Businessline

Action Required: Rehabilitation and Compensation (R&C) staff are asked to familiarise themselves with the Guidelines for Contacting Clients Regarding Negative Decisions available in Chapter 2.6.4 of the Claims Management Guidelines in the Military Compensation Reference Library (MCRL) in the Consolidated Library of Information and Knowledge (CLIK).

Distribute to:
Rehabilitation and Compensation staff

For information:
Secretary
Deputy Secretary | Chief Operating Officer
Deputy President
Commissioner
Deputy Commissioners
First Assistant Secretary, Claims and Operations Division
Rehabilitation and Compensation Directors
Assistant Secretary, Rehabilitation Policy Branch
Assistant Secretary, Compensation and Income Support Policy Branch
Business Improvement and Support Management Group

SUBJECT: Guidelines for Contacting Clients Regarding Negative Decisions

Purpose:
To advise R&C staff of new guidelines for contacting clients via phone in instances where negative decisions may affect a client's wellbeing.

Key Points:

- Good communication with clients is the key to clients having a good relationship with DVA. This is especially important for clients who have severe mental health conditions or complex needs.
- To meet DVA's customer service expectations, all delegates are expected to have an ongoing relationship with their clients. It is imperative that delegates provide timely advice to clients on the progress on their claims to minimise negative decisions being a surprise to them.
- The Department has an Open Door Policy to facilitate timely and constructive communication. In addition to this policy, Administrative Protocols for *Military Rehabilitation and Compensation Act 2004* (MRCA) liability cases mandate that delegates provide progress reports to clients at the 60 and 110 day points.

- However recent reviews of cases and information provided to Senate Inquiries and external agencies suggest that the required levels of communication with clients are not always maintained and therefore DVA's customer service expectations are not always met.
- The Guidelines for Contacting Clients Regarding Negative Decisions have been developed in response to some of these inquiries. They build on the Open Door Policy and Administrative Protocols for MRCA liability cases. They provide direction to delegates about the circumstances in which to contact clients regarding negative decisions. This is especially applicable to decisions relating to mental health conditions or complex cases.
- In situations that meet the criteria outlined in the guidelines (at Attachment A), and prior to the case being determined and the determination letter being published and sent, attempts must be made to contact the client (or their representative) by phone on two occasions over two days. Where the delegate is unsuccessful in making direct phone contact on the first day, the delegate must also send an SMS or email where these contact details are available, to request that the client call back. Negative decisions should never be communicated by SMS or email.
- If contact is unsuccessful, the case may be determined and the determination letter published and sent.
- If the delegate has been unable to contact the client, and because of this the delegate is concerned about the client's welfare, then a referral to the Coordinated Client Support (CCS) unit should be considered. It is important to note that an inability to contact a client is not in itself the sole reason to refer a client to CCS.

Summary:
The intent of these guidelines is to provide a greater level of support to clients who may be affected by certain negative decisions. These guidelines are especially important for clients who have severe mental health conditions or complex needs. The Department's Open Door Policy has been in place since March 2013. This requires compensation delegates to make a phone call to the client at the start of every claim process, whether for a first or subsequent claim. In line with the Administrative Protocols, which have been in place since October 2013, MRCA clients are provided with progress reports at the 60-day and 110-day points of the claims assessment process. Both of these instruments are outlined in Chapter 2.6 of the Claims Management Guidelines in the MCRL.

The Departmental Protocol for Dealing with Clients at Risk has been in place since 2010, and provides guidance for staff on contacting at-risk clients regarding negative decisions.

The Guidelines for Contacting Clients Regarding Negative Decisions has been developed to accompany the above existing procedures. The guidelines identify certain negative decisions, particularly those related to denial of compensation or benefits for mental health conditions, as being potentially detrimental to a client's wellbeing.

Where a negative decision meets the criteria outlined in the guidelines at Attachment A, and prior to the determination letter being sent, attempts must be made to contact the client (or their representative) by phone on two occasions over two days. Where the delegate is unsuccessful in making direct phone contact on the first day, the

delegate must also send an SMS or email where these contact details are available, requesting that the client call back at their earliest convenience. Advice about the negative decision should never be communicated in these SMS or email messages to client. Where the client has voice mail facility the delegate must leave a message requesting the client call back at a convenient time. Where contact is unsuccessful on two occasions over two days, the delegate may proceed with determining the case and publishing and sending the determination letter.

There will be some circumstances in which delegates will be unable to make contact with the client. There will be a variety of reasons for this, however one of them may be that the client is distressed and needs additional support. In these instances, the delegate should consider their knowledge of the client's circumstance's, e.g. whether they have a severe mental health condition or are in financial hardship and consider if a referral to CCS is appropriate. CCS is also available to provide support and advice to delegates on how to manage a client's circumstances.

Further Information:
The Guidelines for Contacting Clients Regarding Negative Decisions are available in CLIK at:

Military Compensation > Military Compensation Reference Library > Claims Management Guidelines > Chapter 2.6.4 Guidelines for Contacting Clients Regarding Negative Decisions

Contact:
Any queries concerning this Businessline should be directed to Lees 47F Assistant Director, R&C Operational Support, Business Improvement and Support Branch on extensions 47F

s 47F

Michelle s 47F
Acting Assistant Secretary
Business Improvement and Support Branch
Claims and Operations Division
19 December 2017

Attachment A – Guidelines for Contacting Clients Regarding Negative Decisions

ATTACHMENT A: Military Compensation Reference Library > Claims Management Guidelines > Chapter 2.6.4 Guidelines for Contacting Clients Regarding Negative Decisions

These guidelines have been developed to assist delegates in handling situations where negative decisions may negatively affect a client's wellbeing. They should be read in conjunction with the Departmental Protocol for Dealing with Clients at Risk (TRIM 12116313E) and followed in conjunction with the Open Door Policy and Administrative Protocols.

Maintaining regular and constructive contact with clients is an important part of the delegate role throughout the lifecycle of the claim. Initial contact should start on receipt of the claim and continue through the process of the claim up to the decision point. Delegates should be guiding the clients through the claims process, highlight concerns and potential outcomes of a claim process so that the outcome is not a surprise.

- Good communication with clients is the key to clients having a good relationship with DVA. This is especially important for clients who have severe mental health conditions or complex needs.
- To meet DVA's customer service expectations, all delegates are expected to have an ongoing relationship with their clients. It is imperative that delegates provide timely advice to the clients on the progress on their claims to minimise negative decisions being a surprise to clients.

Negative decisions that meet the below criteria **must** be communicated to the client (or their representative) via a phone call before determining the case and publishing and sending out a determination letter.
These guidelines recognise that negative decisions will in general be unwelcome for the client and they may not understand the reasons why their claim has been denied. Providing advice for certain negative decisions through a phone conversation provides the opportunity to explain the reasons for the decision, answer any questions the client may have and advise of appeal rights in a much more effective and supportive manner than a determination letter.

1. Is the decision a negative one?
A negative decision is any decision that results in the denial of compensation or benefits to a client, such as: • Denial of liability, incapacity, permanent impairment claims, or special rate disability pension • Denial of cover for disability pension or an increase in disability pension • Denial of cover for war widows/widowers pension • Denial of Non-Liability Health Care • Ceasing incapacity payments • Notification of an overpayment • Commencement of debt recovery reduction in benefits

- Deferral of the final assessment of the degree of permanent impairment where an interim payment is not in place
- Suspension of a rehabilitation program.

2. Is the client managed by Coordinated Client Support?

YES – the role of advising the negative decision should be directed to CCS, where the client will be contacted by their Single Point of Contact or another appropriate person in CCS.	**NO** – the phone call to notify of the negative decision must be delivered by the processing area, with a Team Leader present if necessary. The CCS is not responsible for delivering negative decisions to clients who are not being managed by the CCS service, however they may be contacted for advice in these circumstances. This advice should be sought early to best guide the structure and content of the phone call.

3. Requirement for a phone call

Ensure the below considerations are taken into account prior to arranging the phone call:

- Telephone contact should be attempted two times over two days. Where the delegate is unsuccessful in making direct phone contact on the first day, the delegate must also send an SMS or email where these contact details are available, requesting that the client call back at their earliest convenience.
- The SMS or email should only request a call back from the client and should under no circumstances contain advice regarding the negative decision.
- Set yourself with tasks as a reminder to ring the client.
- Record each attempt at contact as a case note in R&C ISH, or the heritage processing systems where appropriate.
- If you are unable to contact the client, you may leave a message requesting the client call back at a convenient time. Ensure you provide your direct phone number for them to call back on.
- When you have made contact with the client, ensure that you take the time to explain the reason for the phone call and why the determination has been reached. If the client is distressed, provide support options, such as VVCS or information about Non-Liability Health Care. Monitor the client's responses and adjust your tone and responses accordingly; referring to the Managing Challenging Behaviours booklet (TRIM 09222678E) may be useful in preparing to make the phone call.
- The case is to be determined and the determination letter is to be published and sent on the day when successful contact was made, or after two attempts over two days.
- If you have been unable to contact the client, please consider the client's circumstances and if you are concerned about their welfare, then a referral

to the Coordinated Client Support (CCS) unit should be considered; this must be based on the CCS Referral Indicators (TRIM 163587E). It is important to note that an inability to contact a client is not in itself the sole reason to refer a client to CCS.

- Any referral to CCS will result in an intake process which can take several weeks to complete dependent upon information available. During this period, the delegate may request advice from the CCS team to confirm if these guidelines are suitable for delivering the decision taking into account the client's circumstances or more generally on how to manage the client.

4. Considerations

- If the client has a nominated or legal representative, the representative must be notified of the negative decision via a phone call.
- Avoid phoning the client on major commemorative days or other days or times that may be inconvenient for the client, for example contacting a client on a Friday afternoon when support services may not be readily available over the weekend.
- Ensure that you have all relevant information to hand, including information on appeals rights.
- Advise that they will receive written confirmation of the decision shortly.
- Be prepared – should the discussion escalate, follow the Critical Security Incident Protocol (TRIM 10167903E).
- The Protocol for Dealing with Clients at Risk (TRIM 12116313E) can also be referred to for additional guidance on the delivery of negative decisions.

5. Example phone script (this is intended as a guide)

Statement	Supplementary
Hello, this is [Name] from the Department of Veterans' Affairs, the delegate who's been looking after your claim for [insert condition/benefit]. Is now a good time to talk?	As per the Open Door Policy, phone contact should have been made with the client at least once during the investigation process, so the delegate calling may be known to the client. This introduction should be tailored based on the level of familiarity and rapport established between the delegate and the client. If the client is unable to talk, arrange an appropriate time to call them back.
As you know, I've been reviewing your claim in preparation to make a determination. I've now made a determination based on all the evidence we had to hand and I wanted to discuss it with you and go through what it means.	Ensure you refer to previous discussions or correspondence provided to the client, such as the initial phone call, progress reports (as per the MRCA Administrative Protocols) or requests for information.

I'm sorry to advise you that your claim has been unsuccessful at this stage. The reason why is... [provide reasons for the decision]	This is the critical point of the conversation and you should be prepared for a negative reaction from the client. Ensure that you have all the relevant information to hand so that you can go through and clearly explain to the client the reasons for the decision; this is important to support the client's understanding of the decision. For PI decisions: if the condition cannot be accepted because it is not yet stable, it is important to explain this to the client; they may be eligible for PI at a later date. For mental health conditions, ensure you provide details for Non-Liability health Care if the client is not already accessing this service.
I can understand if you are unhappy with this decision and if you wish to pursue it, you have the option of lodging an appeal with any additional information you would like to be reviewed. You have up to 12 months to appeal this decision.	Answer any questions the client has about their appeal rights. If they challenge the elements of the decision as you tell them, advise them that they can lodge an appeal.
E.g. Mental health conditions If you need some support now, I recommend: • contacting your GP • you can call VVCS on 1800 011 046 **E.g. Financial hardship** You may be able to obtain financial support through: • Centrelink or the Department of Human Services • Your local RSL [*provide details*] • The Bravery Trust on 1300 652 103 • RSL DefenceCare on (02) 8088 0388	It is important to provide the client with the most applicable avenues for support. Refer to the Critical Security Incident Protocol (TRIM 10167903E) for escalation if necessary. The support offered should be tailored based on the client's specific needs, e.g. mental health conditions or financial difficulties.
I will be sending a letter to you today that will go into more detail about the decision and the reasons for it. If you	The determination letter should be sent promptly after the phone call.

would like to discuss the decision in more detail after you have received the letter, I encourage you to give me a call. Thank you for your time today. Goodbye.	

Contacting clients regarding negative decisions | CLIK (dva.gov.au)

These guidelines have been developed to assist delegates (including review and reconsiderations officers) when handling situations where negative decisions may negatively affect a client's wellbeing. The department has issued a **Businessline** [1] (CM9 **1979306E** [1]) which also provides guidelines for contacting clients regarding negative decisions. This guidance should be read in conjunction with the **Departmental Protocol for Dealing with Clients at Risk** [2] (CM9 **12116313E** [2]) and followed in conjunction with the Compensation Claims Communication Standards Policy (CM9 **231040357E**)and Administrative Protocols.

The guidelines are:

- Good communication with clients is the key to clients having a good relationship with DVA. This is especially important for clients who have severe mental health conditions or complex needs.
- If at any time during the claims process, you believe the client to be at risk or requires further assistance, consider referring to Client Coordination & Support via the Triage and Connect team. For further information, refer to the CLIK **Engaging with Coordinated Client Support and T&C** page and the **Triage and Connect intranet page**. [3].
- To meet DVA's customer service expectations, all delegates are expected to have an ongoing relationship with their clients. It is imperative that delegates provide timely advice to clients on the progress on their claims to minimise negative decisions being a surprise to clients.

Primary or reconsidered/reviewed negative decisions that meet the below criteria **must** be communicated to the client (or their representative) via a phone call before determining the case and publishing and sending out a determination letter.

These guidelines recognise that negative decisions will in general be unwelcome for the client and they may not understand the reasons why their claim has been denied. Providing advice for certain negative decisions through a phone conversation provides the opportunity to explain the reasons for the decision, answer any questions the client may have and advise of appeal rights in a much more effective and supportive manner than a determination letter.

1. Is the decision a negative one?	
A negative decision is any primary or reconsidered/reviewed decision that results in the denial of compensation or benefits to a client, such as: • Denial of liability, incapacity, permanent impairment claims, or special rate disability pension • Denial of cover for Disability Compensation Payment or an increase in Disability Compensation Payment • Denial of cover for war widows/widowers pension • Denial of Non-Liability Health Care • Ceasing incapacity payments • Notification of an overpayment • Commencement of debt recovery reduction in benefits • Deferral of the final assessment of the degree of permanent impairment where an interim payment is not in place • Suspension of a rehabilitation program.	
2. Is the client managed by CCS, Managed Access or the Wellbeing and Support Program (WASP)?	
YES – the role of advising of the negative decision should be directed to CCS, Managed Access or the WASP where the client will be contacted by their Single Point of Contact or another appropriate person in CCS, Managed Access or the WASP.	**NO** – the phone call to notify of the negative decision must be delivered by the processing area, with a Team Leader present if necessary. The CCS, Managed Access or the WASP are not responsible for delivering negative decisions to clients who are not being managed by those business areas, however they may be contacted for advice in these circumstances. This advice should be sought early to best guide the structure and content of the phone call.
3. Requirement for a phone call	
Ensure the below considerations are taken into account prior to arranging the phone call: • Telephone contact should be attempted two times over two days. Where the delegate is unsuccessful in making direct phone contact on the first day, the delegate must also send an SMS or email where	

1. Is the decision a negative one?	
these contact details are available, requesting that the client call back at their earliest convenience. • The SMS or email should only request a call back from the client and should under no circumstances contain advice regarding the negative decision. • Set yourself with tasks as a reminder to ring the client. • Record each attempt at contact as a case note in R&C ISH, or the heritage processing systems where appropriate. • If you are unable to contact the client, you may leave a message requesting the client call back at a convenient time. Ensure you provide your direct phone number for them to call back on. • When you have made contact with the client, ensure that you take the time to explain the reason for the phone call and why the determination has been reached. If the client is distressed, provide support options, such as Open Arms (formerly known as VVCS) or information about Non-Liability Health Care or consider referring them to Client Coordination & Support via Triage and Connect. Monitor the client's responses and adjust your tone and responses accordingly; referring to the Managing Challenging Behaviours booklet (CM9 **09222678E** [4]) may be useful in preparing to make the phone call. • The case is to be determined and the determination letter is to be published and sent on the day when successful contact was made, or after two attempts over two days. • If you have been unable to contact the client, please consider the client's circumstances and if you are concerned about their welfare, then a referral to the Client Coordination & Support via the Triage and Connect team should be considered; this must be based on the Triage and Connect Referral Indicators (CM9 **18780998E** [5]). It is important to note that an inability to contact a client is	

1. Is the decision a negative one?	
not in itself the sole reason to refer a client to Triage and Connect. • Any referral to Triage and Connect will result in an intake process which can take time to complete dependent upon information available. During this period, the delegate may request advice from the Triage and Connect team to confirm if these guidelines are suitable for delivering the decision taking into account the client's circumstances or more generally on how to manage the client.	
4. Considerations	
• If the client has a nominated or legal representative, the representative must be notified of the negative decision via a phone call. • Avoid phoning the client on major commemorative days or other days or times that may be inconvenient for the client, for example contacting a client on a Friday afternoon when support services may not be readily available over the weekend. • Ensure that you have all relevant information to hand, including information on appeals rights. • Advise that they will receive written confirmation of the decision shortly. • Be prepared – should the discussion escalate, follow the Emergency and Critical Incident Response (incident report process) (CM9 **18780995E** [6]). • The Protocol for Dealing with Clients at Risk (CM9 **12116313E** [7]) can also be referred to for additional guidance on the delivery of negative decisions**.**	
5. Example phone script (this is intended as a guide)	
Statement	**Supplementary**
Hello, this is [Name] from the Department of Veterans' Affairs, the delegate who's been looking after your claim for [insert condition/benefit]. Is now a good time to talk?	As per the Compensation Claims Communication Standards Policy, phone contact should have been made with the client at least once during the investigation process, so the delegate calling may be known to the client. This introduction

1. Is the decision a negative one?	
	should be tailored based on the level of familiarity and rapport established between the delegate and the client. If the client is unable to talk, arrange an appropriate time to call them back.
As you know, I've been reviewing your claim in preparation to make a determination. I've now made a determination based on all the evidence we had to hand and I wanted to discuss it with you and go through what it means.	Ensure you refer to previous discussions or correspondence provided to the client, such as the initial phone call, progress reports (as per the MRCA Administrative Protocols) or requests for information.
I'm sorry to advise you that your claim has been unsuccessful at this stage. The reason why is… [provide reasons for the decision]	This is the critical point of the conversation and you should be prepared for a negative reaction from the client. Ensure that you have all the relevant information to hand so that you can go through and clearly explain to the client the reasons for the decision; this is important to support the client's understanding of the decision. For PI decisions: if the condition cannot be accepted because it is not yet stable, it is important to explain this to the client; they may be eligible for PI at a later date. For mental health conditions, ensure you provide details for Non-Liability Health Care if the client is not already accessing this service. You may consider referring the client to Triage and Connect depending on the outcome of the conversation with the client.
I can understand if you are unhappy with this decision and if you wish to pursue it, you have the option of lodging an appeal with any additional information you would like to be reviewed. You have up to 12 months to appeal this decision. NB: Amend script accordingly for appeal rights if relating to a reconsidered/reviewed decision.	Answer any questions the client has about their appeal rights. If they challenge the elements of the decision as you tell them, advise them that they can lodge an appeal.
E.g. Mental health conditions If you need some support now, I recommend: • contacting your GP	It is important to provide the client with the most applicable avenues for support. Refer to the Emergency and Critical Incident Response (incident report

1. Is the decision a negative one?	
• you can call Open Arms (formerly known as VVCS) on 1800 011 046 **E.g. Financial hardship** You may be able to obtain financial support through: • Services Australia • Your local RSL [*provide details*] • The Bravery Trust on 1300 652 103 (Braverytrust.org.au) • RSL DefenceCare on (02) 8088 0388 (defencecare.org.au) • Soldier On 1300 620 380 (soldieron.org.au)	process) (CM9 **18780995E** [6]) for escalation if necessary. The support offered should be tailored based on the client's specific needs, e.g. mental health conditions or financial difficulties.
I will be sending a letter to you today that will go into more detail about the decision and the reasons for it. If you would like to discuss the decision in more detail after you have received the letter, I encourage you to give me a call. Thank you for your time today. Goodbye.	The determination letter should be sent promptly after the phone call.