Australian Government
Department of Veterans' Affairs

IMPORTANT

Application for Recreation Transport Allowance

Recreation transport allowance

The Department of Veterans' Affairs (DVA) recognises and supports the need for veterans to be able to travel for recreational purposes, such as attending sporting events, social outings or visiting friends and family. Recreation transport allowance is a fortnightly payment to assist eligible veterans with severe war or defence-caused disabilities accepted under the *Veterans' Entitlements Act 1986* (VEA) which affect their mobility.

The allowance is intended to supplement the extra transport costs that may be incurred for veterans to access appropriate and available modes of transport to attend recreational activities. There are two rates of payment - a high rate or a low rate, depending on the extent of the veterans' war or defence-caused disabilities.

If you are not already undertaking travel for social and recreational purpose, you can still apply on the basis of future plans for such travel.

NOTE: For more information, please refer to Factsheet DP76 - Recreation Transport Allowance. The allowance is not payable if you are being cared for in a hospital or institution and do not make any patient contribution towards your stay. The allowance is also not payable if you cease to travel for recreational purposes, or if you participate in the Vehicle Assistance Scheme.

Assistance from ex-service organisations

You are encouraged to seek the assistance of an ex-service organisation of your choice in lodging this application.

Contact telephone numbers for these organisations can be found in local telephone directories or by contacting the DVA in your State.

Assistance from DVA

DVA staff can also help to complete this form.

Completing this form

This form is in 3 parts and asks for details about:

PART A -	your nominated representative, if any; such as name and contact details.
PART B -	yourself and your mobility restrictions.
PART C -	your loss of powers of locomotion. If you are applying on the basis of an amputation or blindness in both eyes, **no medical report** is required. For any other loss of the powers of locomotion, PART C is to be completed by a Medical Officer.

Privacy notice

Your personal information is protected by law, including the *Privacy Act 1988*. Your personal information may be collected by the Department of Veterans' Affairs (DVA) for the delivery of government programs for war veterans, members of the Australian Defence Force, members of the Australian Federal Police and their dependants.

Read more: How DVA manages personal information

Giving false or misleading information is a serious offence.

If any details you give on this form change, you must tell the Department within twenty one (21) days.

How to contact DVA

For information, please call the Department of Veterans' Affairs (from anywhere in Australia) on: **1800 555 254**

State	Address	Postal address
New South Wales	Centennial Plaza Tower B 280 Elizabeth Street Sydney NSW	GPO Box 9998 Brisbane QLD 4001
Victoria	300 Latrobe Street Melbourne VIC	GPO Box 9998 Brisbane QLD 4001
Queensland	Bank of Queensland Centre 480 Queen Street Brisbane QLD	GPO Box 9998 Brisbane QLD 4001
South Australia	Westpac House 91 King William Street Adelaide SA	GPO Box 9998 Brisbane QLD 4001
Western Australia	AMP Building 140 St Georges Terrace Perth WA	GPO Box 9998 Brisbane QLD 4001
Tasmania	Barrack Place 254 - 286 Liverpool Street Hobart TAS	GPO Box 9998 Brisbane QLD 4001
Northern Territory	Winnellie Central 14 Winnellie Road Winnellie NT 0820	GPO Box 9998 Brisbane QLD 4001
Australian Capital Territory	6 Bowes Street Woden ACT 2606	GPO Box 9998 Brisbane QLD 4001

PART A Representative's details

To be completed only if you wish to nominate a representative to act for you in matters relating to this application

1 Do you wish to nominate a representative or organisation to act for you in matters related to this application?

No ☐ ▶ Go to **Question 3**

Yes ☐ ▶ Full name of nominated representative

Organisation *(if applicable)*

Address

POSTCODE

Telephone

Home ( )

Work ( )

Facsimile ( )

E-mail address

2 Is the representative trained under the Training and Information Program (TIP)?

No ☐ Yes ☐ ▶ To what level?

PART B Applicant's details

To be completed by the person who is claiming recreation transport allowance

3 DVA File Number (if known)

4 Your surname

5 Your given names

6 Postal address

POSTCODE

7 Telephone number(s)

Home ( )

Work ( )

Mobile

Facsimile ( )

E-mail address

8 Where would you usually go for recreational purposes (such as visiting friends and family or attending sporting or social events etc.)?

9 **How do you or would you travel there (such as train, bus, taxi, friend's car etc.)?**

10 **Which category best describes your accepted disability or its effects on your mobility?**

Please tick ONE box.

NOTE: If applying on the grounds of G or H, then PART C must be completed by a Medical Officer

A	Both legs amputated above the knees	☐ ▶ Go to **Question 13**
B	Both arms amputated at or above the wrists	☐ ▶ Go to **Question 13**
C	Both legs amputated below the knees	☐ ▶ Go to **Question 13**
D	One leg amputated above the knee and the other below the knee	☐ ▶ Go to **Question 13**
E	One leg amputated above or below the knee and one arm amputated below the elbow	☐ ▶ Go to **Question 13**
F	Blinded in both eyes	☐ ▶ Go to **Question 13**
G	Very limited ability to walk or otherwise move around, and only able to walk or move any distance with the aid of crutches or walking sticks, and only for short distances.	☐ ▶ Go to **Question 11**
H	Unable to walk or otherwise move around to an extent similar to any disabilities listed above.	☐ ▶ Go to **Question 11**

11 **What is the disability (or disabilities) that affects your mobility?**

12 **How does this disability affect your ability to move about inside the home and outside?**

If you need someone to assist you, please describe what they do to assist. Comment on performing daily activities and undertaking social and recreational activities.

13 **Are you being cared for in a hospital or other institution?**

No ☐

Yes ☐ ▶ Are you paying a contribution towards your care?

No ☐

Yes ☐

14 **Have you participated in or are you participating in the Vehicle Assistance Scheme?**

No ☐

Yes ☐

Declaration and Consent

NO REPRESENTATIVE APPOINTED

Please complete if you do not have a representative appointed in PART A.

I declare that the details I have given in this form are complete and correct.

I am aware that giving false or misleading information is a serious offence.

I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.

I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

YOUR SIGNATURE

Date / /

REPRESENTATIVE APPOINTED

Please complete if you have a representative appointed in PART A.

I declare that the details I have given in this form are complete and correct.

I am aware that giving false or misleading information is a serious offence.

I authorise the Repatriation Commission and the Department of Veterans' Affairs to obtain medical or other information, or to use such information already in its possession, needed to process, determine or review this application.

I authorise the nominated representative or organisation to act for me in respect of this application and any reviews in respect of this or subsequent decisions. This authorisation will continue until I:

- revoke the authorisation; or
- nominate another representaive or organisation to act for me.

I consent to the release of medical, clinical or other information to the Department, by any medical practitioner, hospital, clinic, insurance company, Centrelink or other organisation, in relation to this application or its review.

YOUR SIGNATURE

Date / /

PHYSICAL OR MENTAL INCAPACITY

If the veteran is unable to sign due to physical or mental incapacity, please sign on behalf of the veteran at either 'NO REPRESENTATIVE APPOINTED' or 'REPRESENTATIVE APPOINTED' above and provide the following details.

Your full name

Address

POSTCODE

Telephone

Home ( )

Work ( )

Please attach a copy of the document that gives you legal authority to act on behalf of the veteran, unless this has already been provided to the Department.

I declare that I am authorised to act on behalf of the veteran in matters relating to this application. *(Tick one box below).*

☐ I have attached a copy of the authority document or a medical certificate attesting to this incapacity.

☐ I have provided DVA with a copy of *Type of document*

Save

Print

Clear

YOUR SIGNATURE

Date / /

PART C Medical report

To be completed by a Medical Officer only if the veteran is claiming on the grounds of negligible or handicapped powers of locomotion as indicated by ticking boxes **(g)** and **(h)** at **Question 10** in **PART B**.

The Department will pay for this service according to *The Schedule of Fees.* An account showing the time spent in consultation must be lodged before payment can be made.

15 Veteran's surname

16 Veteran's given names

17 Does the veteran suffer from any diseases or injuries that affect mobility?

No ☐ ▶ Please sign the form on the next page

Yes ☐ ▶

Disease/injury

Effect on mobility

18 Can the veteran move about without assistance from another person?

No ☐ ▶ Please describe the assistance provided

Yes ☐

19 Does the veteran use crutches or walking sticks?

No ☐

Yes ☐ ▶ How far can the veteran walk **with** crutches or walking sticks?

How far can the veteran walk **without** crutches or walking sticks?

20 Does the veteran use any other mobility aid?

No ☐

Yes ☐ ▶

Type of aid

When used

21 Is the veteran capable of travelling for recreational purposes (with or without assistance)?

No ☐ ▶ Please provide reasons

Yes ☐

Medical Officer's details

22 Your name (please PRINT).

23 Address

POSTCODE

24 Contact phone number

( )

25 Signature

YOUR SIGNATURE

Date

/ /