F

FAMILY

INFIRM BENEFIT

PURPOSE

- Payment made to individuals who cannot work or support self by own means or labour due to illness or disability.
- A payment of **$100** will be paid out on the **1st and the 16th of each month.**

FOR WHOM

- Adult person age **16 years** and **over.**
- Cook Islander or Permanent Resident.
- Residing in the Cook Islands.

APPLY

1. Collect application from Main Office in Tupapa OR phone to have form emailed to you. To download application visit our website **www.intaff.gov.ck**
2. Fill and sign form; attach required documents.
3. Submit complete application to Main Office or email it to: **welfare@intaff.gov.ck**
4. A Welfare Officer will contact you in regards to your application once received—to carry out an Assessment.

For any enquiries please call +682 29370 or send through your query via email above.

YOU NEED

- Valid Passport or Birth Certificate.
- Medical Certificate/Report from a Registered Doctor—(Medical certificate form will be provided with application form by Internal Affairs).
- BCI Letter – Confirming Bank Account Details.
- Applicant's Valid ID—Drivers License or Passport.

TE TANGO AKARANGATIRA ORA'ANGA INTERNAL AFFAIRS

GOVERNMENT OF THE COOK ISLAND

CHECKLIST FOR AN INFIRM APPLICATION

Eligibility:

- ☐ 16 Years and Over
- ☐ Unable to work due to illness or disability

Supporting Documents:

- ☐ Passport or Birth Certificate
- ☐ Medical Certificate/Report from Registered Doctor
- ☐ Assessment by Welfare Inspector
- ☐ Letter from BCI – Confirming Bank Account Details

GOVERNMENT OF THE COOK ISLANDS
MINISTRY OF INTERNAL AFFAIRS
P O Box 98, Rarotonga, Cook Islands * Tel: (682) 29-370 * Fax: (682) 23-608 * E-mail: welfare@intaff.gov.ck

SOCIAL WELFARE BENEFIT/ ASSISTANCE APPLICATION FORM

Please complete all questions – if not applicable write N/A.

☐ **New application** ☐ **Reapplying**

PLEASE INDICATE THE TYPE OF BENEFIT/ ASSISTANCE YOU ARE APPLYING FOR:

☐ OLD AGE PENSION ☐ CHILD BENEFIT ☐ NEW BORN ALLOWANCE

☐ INFIRM RELIEF ☐ DESTITUTE RELIEF

SUPPORTING DOCUMENTS

I have provided all the required supporting documents

☐ Birth Certificate/ Birth Notification ☐ Passport ☐ BCI Bank Card/ Passbooks

REF: _____ REF: _____ A/C Name: _____

RMD No#:_____ Tax Rate _____ EXP: _____ A/C No: _____

BENEFICIARYS' DETAILS

FIRST NAME: _____

SURNAME: _____

Date Of Birth: _____/_____/_____ **GENDER:** ☐ MALE ☐ FEMALE

CONTACT DETAILS

ISLAND: _____ **VILLAGE:** _____

Phone: _____ **Mobile:** _____ **Email** _____

Postal Address: _____

RESIDENCY

I (the beneficiary) am a:

☐ Cook Islander born in the Cook Islands ☐ Cook Islander born overseas ☐ Cook Islands permanent resident

Date: _____ / _____ /_____

☐ Other *(please give details):* _____

When did you (the beneficiary) arrive in the Cook Islands: _____/ _____/ _____

YOUR DETAILS (person whom completed the application form)

FIRST NAME: _____ SURNAME: _____

Your relationship to the beneficiary: Your contact number:

_____ _____

The information I have provided is true and complete. The conditions of receiving this benefit/assistance have been explained to me and I understand these conditions.

Signature of applicant: _____ **date**: _____

OFFICE USE ONLY

Statement by Officer: I have explained the conditions for receiving of this benefit/ assistance and explained what the clients obligations means and the reason for them. The client has indicated that he/ she understands and accepts responsibility to provide true and complete information and to advise immediately of any changes in circumstances. All questions have been completed.

Name (print) _____ Signature _____ date _____

Additional Information:

_____
__
_____
__
_____
__
_____
__
_____

(Outer Islands/ Rarotonga)

Application received by: _____

Dates

Application received: _____
Supporting documents : _____
Supplementary documents: _____
Referred to Main Office _____
O/Island Application No. _____
Head Office Application No. _____

(Rarotonga ONLY)

Application received by:

_____

Dates

Pay period: _____
Payment amount: _____
Other payment: _____
Payment amount: _____
Addition Voucher No. _____
Main Vchr from: _____

FOR DIRECTOR/ COMMITEE

Decision:

_____
_____
_

FOR THE REGISTRAR OF BIRTHS or HIGH COURT *(Old Age Applications ONLY)*

I, _____, Deputy Registrar/ Registrar of Births (or the High Court) at Rarotonga, pursuant to Section 42 of the Welfare Act 1989, hereby verify & certify that applicant was born on: _____ and has reached the age of 60 years.

REFERENCE DETAILS: _____

Signature: _____ *Date: _____*

EMPLOYMENT STATUS OF MOTHER (For maternity leave considerations)

Are you currently in full time employment YES / NO PRIVATE / GOVERNMENT / OTHER

CLIENTS OBLIGATIONS

OFFICE COPY

Please read this statement carefully and sign.

I must tell Social Welfare immediately if:

- I intend to TRAVEL OVERSEAS, whether for holiday or permanently
- My personal details change (such as name, address or bank account)
- I am granted an overseas benefit payment
- My living arrangement and circumstances changes.

I understand that:

- if I have made a false statement ***or***
- if I have failed to answer all the questions in full ***or***
- If I do not tell Social Welfare about changes that it might affect my entitlement or rate.

Then:

- The benefit/ assistance may be reviewed and cancelled ***and***
- I may have to pay back the total amount of any overpayment that I have received ***and***
- I may be prosecuted and fined

My obligations have been explained to me and I understand my responsibilities

Name: _____ Signature: _____ Date: _____

Witnessed by: _____

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WORK CAPACITY MEDICAL CERTIFICATE

FIRST NAME: _____

SURNAME OR FAMILY NAME: _____

DATE OF BIRTH: _____

HOSPITALISATION - Is the person in Hospital YES NO

SICKNESS, INJURY OR DISABILITY - What are the main clinical conditions affecting the person's ability to work?

Is the person blind? YES NO

How do the conditions listed previously impact on the person's capacity for work and the type of work they can undertake? IMPACT SEVERELY SOME IMPACT MINIMAL IMPACT

IMPACT ON CAPACITY FOR WORK?

Do the conditions listed previously limit the person's capacity to work for 30 hours or more per week? YES NO

Do the conditions listed previously limit the person's capacity to work regularly in open employment for 15 hours or more a week? YES NO

Is the person's incapacity for work expected to last at lest 2 years? YES NO

Is the person's life expectancy less than 2 years? YES NO

Does the person receive active treatment or under the care of a specialist for any of the conditions listed previously? YES NO

When is the person likely to be capable of:

(a) Work planning within 3 months within a year after a year

(b) Limited training (less than 15 hours per wk) within 3 months within a year after a year

(c) Training (at least 15 hours per week) within 3 months within a year after a year

(d) Limited part time work (less than 15 hrs pw) within 3 months within a year after a year

(e) Part-time work (at least 15 hrs per week) within 3 months within a year after a year

(f) Full-time work (30 hours or more per week) within 3 months within a year after a year

Are there any other treatments or interventions that could assist the person into work? YES NO

Unable to work from: _____

When should the person's capacity for work next be assessed: _____

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COMMENTS

Please provide any comments that would assist Internal Affairs to determine entitlement to benefit or assist the person into work.

HEALTH PRACTITIONER IDENTITY

DECLARATION:

I declare the above information to be true and correct to the the best of my knowledge. I understand if I produce any false or misleading information in accordance to this application, I may be prosecuted and fined.

Full name: _____

Address: _____

Telephone: _____

Date person examined: _____

Date certification completed: _____

Profession: _____

Health practitioner signature: _____