Explaining the Disability Support Pension

This fact sheet summarises the Ask LOIS webinar on this topic, presented Jessica Raffal, Lawyer, Women's Legal Service NSW on 7 April 2016.
This webinar can be viewed for free at www.asklois.org.au/webinars/past-webinars.

This factsheet looks at:
What are the qualification criteria for Disability Support Pension?
What is a program of support?
How can a rejection of a claim for DSP be appealed?
What kind of medical evidence is necessary?
Where can your client get help?

What are the DSP qualification criteria?

- Aged between 16 and Age Pension age
- Meet residence requirements
- Meet income and assets tests
- **Be permanently blind or have 20 points of impairment under the impairment tables**
- **Have a continuing inability to work as a result**
    - **Participation in a program of support (if relevant)**

Medical qualification criteria

Impairment Tables

There are 15 impairment tables which correspond to different areas of function impairment. They are:

Table 1 - Functions requiring Physical Exertion and Stamina
Table 2 – Upper Limb Function
Table 3 – Lower Limb Function
Table 4 – Spinal Function
Table 5 – Mental Health Function
Table 6 – Functioning related to Alcohol, Drug and Other Substance Use
Table 7 – Brain Function
Table 8 – Communication Function
Table 9 – Intellectual Function
Table 10 – Digestive and Reproductive Function
Table 11 – Hearing and other Functions of the Ear
Table 12 – Visual Function
Table 13 – Continence Function
Table 14 – Functions of the Skin
Table 15 - Functions of Consciousness

They can be found here:
https://www.dss.gov.au/our-responsibilities/disability-and-carers/benefits-payments/disability-support-pension-dsp-better-and-fairer-assessments/review-of-the-tables-for-the-assessment-of-work-related-impairment-for-disability-support-pension/social-security-tables-for-the

Points are allocated to functional impairment, not to individual conditions. This means that some conditions may give rise to points under multiple tables (eg. A stroke could potentially give rise to points under nearly every table, depending on the individual case). This also means sometimes multiple conditions can lead to points under only one table (eg. A shoulder injury and a hand injury probably will mean points under only table 2).

Each table outlines what 0, 5, 10, 20 and 30 points will mean for that impairment, using practical examples. Eg, the following is 10 points under table 4 (spinal function):

The person is able to sit in or drive a car for at least 30 minutes, and at least one of the following applies:

(a) the person is unable to sustain overhead activities (e.g. accessing items over head height); or

(b) the person has difficulty moving their head to look in all directions (e.g. turning their head to look over their shoulder); or

(c) the person is unable to bend forward to pick up a light object placed at knee height; or

(d) the person needs assistance to get up out of a chair (if not independently mobile in a wheelchair).

Permanent Condition

Conditions must be permanent to get any points. "Permanent" means:

- Fully diagnosed by appropriate qualified medical practitioner; and
- The condition has been fully treated; and
- The condition has been fully stabilised; and
- The condition is more likely than not, in light of available evidence, to persist for more than 2 years.
- In cases of terminal illness with a life expectancy of less than 2 years, the condition **can** be considered permanent.

If any of these criteria have not been met, no points will be assigned to the impairment.

Fully Diagnosed

- Appropriately qualified medical practitioner.
- Generally unspecified, policy states: *Appropriately qualified medical practitioner means a medical practitioner whose qualifications and practice are relevant to diagnosing a particular condition.*
- Occasionally form of diagnosis or qualifications of medical practitioner/provider of additional evidence is prescribed
- **Most common:** Table 5 requires psychiatrist or clinical psychologist – registered psychologist **is not** sufficient

Fully treated

- If future treatment is planned or required, no points can be allocated
- **Unless** it is clear that future treatment will not significantly improve person's functional capacity within next 2 years
- If treatment is scheduled but there is a long wait list and it will not be undertaken in the next two years, that condition **can** be considered permanent

Fully stabilised

- The person has undertaken all reasonable treatment for the condition
- Any further reasonable treatment is unlikely to result in significant functional improvement
- "Reasonable" = location, cost, success rate, risk
- Can refuse for "medical or other compelling reason" (eg. Jehovah's witness and blood transfusion, no capacity to consent to treatment)

20 Points of Impairment

Once the above criteria are met and the condition has been found to be **permanent**, points can be allocated.

The Job Capacity Assessor will look at the claimant's medical evidence and also conduct their own assessment to gauge the level of the impairment and assign a rating of points under the tables.

There is no limit to the number of tables someone can get points under, and a person can combine points under different tables in order to reach the necessary minimum of 20. If someone does this, and does not have 20 points under a **single table**, additional requirements exist, see "Program of Support" below.

Continuing Inability to Work

Person must 20 points **and** a continuing inability to work (CITW)

CITW means impairment is sufficient to prevent the person:

- working more than 15 hours per week within next 2 years **and**
- undertaking a training activity that is likely to enable the person to increase their capacity to work independently to greater than 15 hpw in the next 2 years

In order to be granted at claim, working capacity must be 15 hours per week or less. Once granted, it is possible to work up to 30 hours per week without becoming unqualified, **but**:

- If this is consistent there is a risk of cancellation
- Income affects rate of payment (except for blind pension which is not income tested)

Program of Support

Unless a person has 20 points under a single table, in order to be assessed as having a CITW that person must have **actively participated** in a program of support (POS) for 18 out of the 36 months prior to claim.

In practice, this nearly always means active participation in the Newstart allowance requirements. **Active participation** means any periods of temporary exemption from participation (usually 3 months on the basis of a medical certificate) **do not count towards the 18 months.**

Worker's compensation programs can count but only if it started before 1 January 2015.

There are possible exceptions:

- Program less than 18 months (will not apply to Newstart program)
- Program terminated early (will not apply to Newstart program)
- Participating at date of claim because disability will not benefit from POS (very difficult to demonstrate).

Very few people will be able to demonstrate that these exceptions apply, and the reality is that **almost everyone** who gets 20 points but not under a single table will have to do a POS to qualify.

20 points under a single table is a severe level of impairment, but it is more severe for some impairments than others. Getting 20 points under Table 5 – mental health function – requires a much higher level of impairment than it does under many other tables.

Claims and Appeals

To claim:

- Call Centrelink and lodge an intent to claim
- Claim for Newstart allowance at the same time
- Follow up with basic written claim within 14 days
- Follow up with medical evidence ASAP after that

Evidence

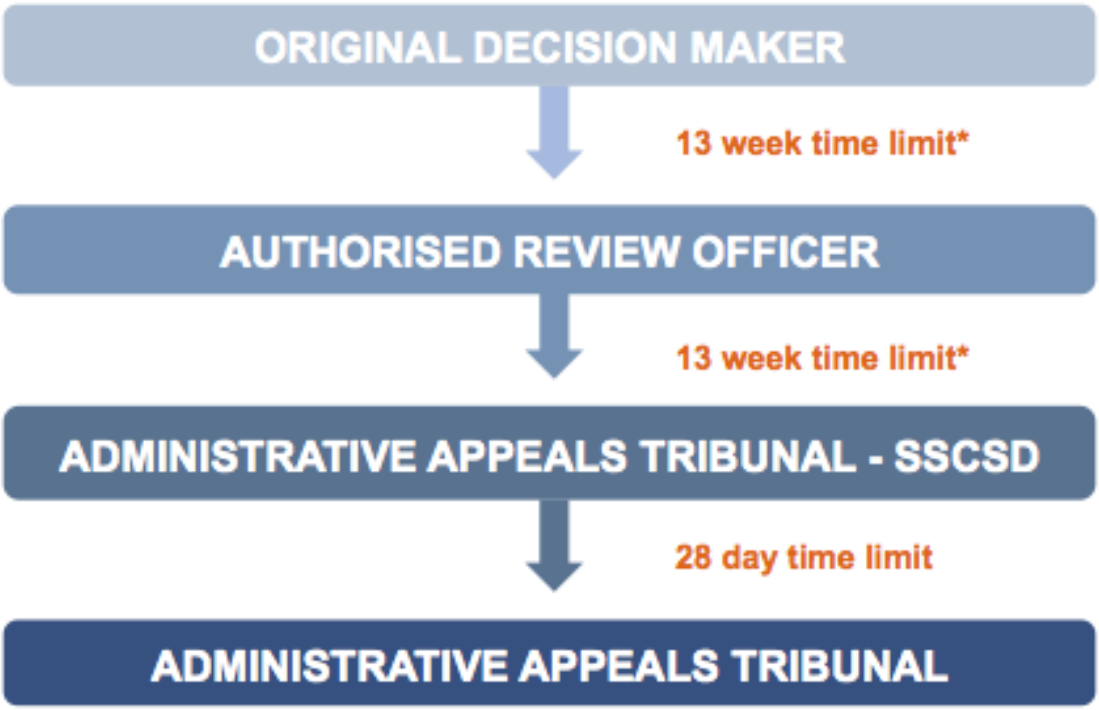
Medical evidence is most important factor

Letters from doctors should:

- Address impairment tables
- Use language of tables and list which egs. Relate to clients
- Assign rating
- Note other relevant factors (eg. Wait list, future treatment)

Appeals

Nearly all Centrelink decisions can be appealed. The appeal chain is:



13 week time limit

The 13 week time limits marked with an asterisk apply to Centrelink decisions to cancel, reject, suspend or reduce someone's payment. If someone lodges an appeal within that 13 week period and they are ultimately successful, they will be paid from the date they lodged their claim. This is true even if their appeal is not heard for a year or more – they will receive a lump sum of arrears. They are not true time limits as these decisions **can** be legally appealed outside of this time, but if they are then the person is only entitled to backpay from the date of lodging the appeal (if they are ultimately successful). This means that if the 13 week time limit has passed, it will **usually but not always** be simpler and better to make a new claim instead of appealing.

There is **no time limit** for appealing a Centrelink debt.

28 day time limit

The 28 days time limit is a part of the rules of the Administrative Appeals Tribunal and applies to all decisions including debts, from the AAT Social Services and Child Support Division.

Extensions can be granted in limited circumstances. If you are requesting an extension you must show:

1. Good reason for the delay (the longer the delay the better the reason); and
2. Merit in the substantive appeal.

All these levels of appeal will be conducting **merits review**. This means that they will look at all the facts and law again and make a fresh decision. They will "stand in the shoes" of the original decision maker, so that if they make a new decision, the original decision itself gets changed. This means that throughout the appeals process, the relevant point in time is the **date of claim**. This may be a year or more before a Tribunal hearing, and it is possible for someone to have qualified in the meantime. Even in this case, unless the person can demonstrate that they qualified at the **date of claim**, their appeal will be unsuccessful.

New evidence

New evidence **can** be submitted throughout the appeals process but that evidence **must** relate to condition at date of claim

Evidence re: a new diagnosis or treatment will generally mean condition was **not fully diagnosed** (or treated) at date of claim = no points

A new claim is required to have that new diagnosis considered

A new claim can be made while an appeal is ongoing

Resources

- Welfare Rights Centre
  www.welfarerightscentre.org.au

- Legal Aid NSW
  http://www.legalaid.nsw.gov.au/what-we-do/civil-law/social-security-service

- National Welfare Rights Network resources:
  http://www.welfarerights.org.au/factsheets

- DSS Guide to Social Security Law: http://guides.dss.gov.au/guide-social-security-law

- Centrelink Guide to Australian Government Payments:
  http://www.humanservices.gov.au/corporate/publications-and-resources/a-guide-to-australian-government-payments