Help using this PDF claim form

In this PDF form we have introduced a special feature that lets you save it in Adobe Reader 8.1.2 and later. This means that you no longer have to complete the form in one session.

This form will only work if you:
• save it to your computer, then
• open it in Acrobat Reader version 8.1.2 or later.

The form will not work in:
• older versions of Acrobat Reader
• other pdf readers, for example *Preview* on a Mac or *Foxit* on a PC
• your web browser window.

If you are having technical difficulties:
• downloading the form
• Navigating around the form, or
• printing the form

Please contact the **eService helpdesk**.
Phone: **0845 601 80 40**
Minicom (textphone): **0845 601 80 39**
Email: **eservicehelpdesk@dwp.gsi.gov.uk**

Opening hours
Monday to Friday: 08.00am - 09.00pm
Weekend: 08.00am - 04.00pm
Closed on all Public and Bank Holidays.

For help and advice on the information you need to put on the form or about the benefit you want to claim, contact the office that deals with the benefit.

We would like your feedback about this PDF claim form

We would like your feedback about this form. We will use any comments to improve future versions. Please email your comments to:

forms.feedback@dwp.gsi.gov.uk

Go back

Please do not send personal information or questions about your benefit or entitlement to this email address.

Limited capability for work questionnaire

jobcentreplus

Department for Work and Pensions

This form is available in Welsh from **www.gov.uk** or by ringing **0345 608 8545**.
Please fill in this form with BLACK INK and in CAPITALS.

The Department for Work and Pensions needs you to fill in this questionnaire if you are making a claim for benefits or National Insurance credits on the basis of limited capability for work.

This questionnaire asks questions about your physical and mental health. Your answers will tell us how your illness or disability affects your ability to work. We need this information to decide if you can get benefits.

Please send this questionnaire back by the date given in the enclosed letter. If you send the questionnaire in late, use **page 17** to tell us why.

How to fill in this questionnaire

1. Answer all the questions

Every question has instructions to take you step-by-step to the end of the questionnaire. You may wish to fill it in a bit at a time as it may take some time to complete.

Use the boxes after each question to tell us in your own words how your illness or disability affects how you do day-to-day things. Tell us if your ability to function varies over time. For example, over days, weeks, months or longer.

If you need more space to answer any of the questions, please use the box on page 17, or use a separate piece of paper.

2. Send us any medical information you want us to see

It is important that you give us as much information as possible as this helps us to deal with your claim.

If you have any medical information from your doctor, consultant or health care professional, or any other information which you wish us to see, please send us a copy with this questionnaire.

You do not have to see your GP or health care professional to ask for a specially written report. You may be charged if you do this.

Help filling in this questionnaire or any part of it

You can ask a friend, relative or representative to help you, or get in touch with Jobcentre Plus. The person from Jobcentre Plus will go through the questions with you over the phone.

Sometimes they may be able to fill in the questionnaire for you. If they do this, they will send the questionnaire to you. You can then check it, sign it and send it back.

You can ask for a questionnaire in braille or large print. Or you can download the questionnaire to your computer and fill it in. Send it to the address on the envelope we have sent you.

For information about benefits and services visit **www.gov.uk**. Or call us on the number in the attached letter.

About you

Surname

Other names

Title Title

Address

Postcode

Date of birth

National Insurance (NI) number Letters Numbers Letter

Are you pregnant?

No

Yes When is your baby due?

Face-to-face assessment

You may be asked to attend a face-to-face assessment with a qualified healthcare professional. Medical Services would like to telephone you between 9.00am and 8.30pm on Monday to Friday, or between 9.00am and 5.00pm on Saturday to arrange a suitable date and time. To do this we need you to give us at least one up-to-date telephone number so that we can contact you.

If you want more information about the face-to-face assessment, visit **www.gov.uk**

Daytime phone number Code Number

Mobile phone number

Any other number including Textphone number Code Number

If you do not understand English or Welsh, or cannot talk easily in these languages, do you need an interpreter?
You can bring your own interpreter to the assessment, but they must be over 16.

No

Yes What language do you want to use?

Tick this box if you will bring your own interpreter.

Would you like your telephone call in Welsh?

No

Yes

Would you like your face-to-face assessment in Welsh?

No

Yes

Tell us about any times or dates in the next 3 months when you cannot go to a face-to-face assessment.

Tell us about any help you would need if you have to go for a face-to-face assessment.

Tell us if

- you cannot get up and down stairs
- have difficulty travelling or using public transport
- you need a British Sign Language signer.

Tell us about any other help you might need.

About your treatment

Please tell us who your GP is. If you want to, you can also tell us about another health or care professional who knows you and your condition best. Sometimes we will need to contact these people to ask them for medical information. We do not do this for every claim.

What is your GP's name

Their address

Postcode

Their phone number

Code Number

When was your most recent appointment?

Please give us the details of the care professional who knows you or your condition best. For example:

- consultant or specialist doctor
- specialist nurse
- physiotherapist
- occupational therapist
- community psychiatric nurse
- support worker or personal assistant
- social worker.

Their name

Their address

Postcode

Their phone number

Code Number

When was your most recent appointment?

Cancer treatment

Are you having, waiting for or recovering from chemotherapy or radiotherapy treatment for cancer?

No ☐

Yes ☐ If your single health problem is cancer treatment and its effects on you, you do not have to complete the rest of the questionnaire if you don't want to.

If you have other health problems as well as cancer treatment, please complete the rest of the questionnaire.

In either case, make sure you sign **page 18** and make sure **page 20** is filled in by a healthcare professional. This may include a GP, hospital doctor or clinical nurse who is aware of your condition.

About your illnesses or disabilities

We will ask you specific questions about how your illnesses or disabilities affect how you do day-to-day things in the rest of this questionnaire.

Please use the space on this page to tell us

- **what your illness, disability or condition is**
- **how it affects you, and**
- **when it started.**

If your condition varies over time, tell us how.

Please also tell us about

- **any aids you use, such as a wheelchair or hearing aid**
- **anything else you think we should know about your illness or disabilities.**

If you need more space, please use **page 17** or a separate sheet of paper.

About your medication

Details of tablets or other medication
Please also tell us about any tablets or other medication you are taking or will be taking, including any side effects you have.

If you need more space, please use **page 17** or a separate sheet of paper.

Hospital, clinic or special treatment

Use this section to tell us about
- any hospital or clinic treatment you are having
- any hospital or clinic treatment you expect to have in the near future
- any special treatment you are having, such as dialysis.

Please also tell us about any special treatment you have which you may not go to a hospital or clinic for.

Are you having or waiting for any hospital or clinic treatment which needs you to stay overnight or longer?

No ☐
Yes ☐

Tell us about all your hospital and clinic visits here.

Tell us how often you visit the hospital or clinic and why.

If you need more space, use the space on **page 17** or a separate sheet of paper.

Drugs, alcohol or other substances

Do you think any of your health problems are linked to drug or alcohol misuse, or misuse of any other substance?

No ☐ Go to **Part 1**.

Yes ☐ Use this space to tell us more about these problems and how they affect your health. By *drugs* we mean drugs you get from your doctor **and other drugs**.

Are you in a residential rehabilitation scheme?

No ☐ Go to **Part 1**.

Yes ☐ Tell us the name of the organisation running your scheme, when your treatment began and when you expect it to end.

Part 1: Physical functions

To answer Yes to any of the following questions, you must be able to do the activity safely, to an acceptable standard, as often as you need to and in a reasonable length of time.

1. Moving around and using steps

By *moving* we mean including the use of aids such as a manual wheelchair, crutches or a walking stick, if you usually use one, but without the help of another person.

Please tick this box if you can move around and use steps without difficulty.

☐ Now go to **question 2**.

How far can you move safely and repeatedly on level ground without needing to stop?
For example, because of tiredness, pain, breathlessness or lack of balance.

☐ 50 metres – this is about the length of 5 double-decker buses, or twice the length of an average public swimming pool.

☐ 100 metres – this is about the length of a football pitch.

☐ 200 metres or more

☐ It varies

Use this space to tell us how far you can move and why you might have to stop. If it varies, tell us how.

Tell us if you usually use a walking stick, crutches, a wheelchair or anything else to help you, and tell us how it affects the way you move around.

Going up or down two steps

Can you go up or down two steps without help from another person, if there is a rail to hold on to?

☐ No

☐ Yes – now go to **question 2**

☐ It varies

Use this space to tell us more about using steps. If it varies, tell us how.

2. Standing and sitting

Please tick this box if you can stand and sit without difficulty.

☐ Now go to **question 3**.

Can you move from one seat to another right next to it without help from someone else?

☐ No
☐ Yes
☐ It varies

How long can you stay in one place, either standing, sitting, or a combination of the two, without help from another person, without pain or exhaustion?
This does not mean standing completely still. It includes being able to change position.

☐ Less than 30 minutes.
☐ 30 minutes to one hour.
☐ More than one hour.
☐ It varies.

Use this space to tell us more about standing and sitting and why this might be difficult for you.

Tell us how long you can sit for and how long you can stand for. Tell us what might make it difficult for you. If it varies, tell us how.

3. Reaching

Please tick this box if you can reach up with both your arms without difficulty.

☐ Now go to **question 4**.

Can you lift at least one of your arms high enough to put something in the top pocket of a coat or jacket while you are wearing it?

☐ No
☐ Yes
☐ It varies

Can you lift one of your arms above your head?

☐ No
☐ Yes
☐ It varies

Use this space to tell us more. Tell us why you might not be able to reach up, and whether it affects both arms. If it varies, tell us how.

4. Picking up and moving things

Please tick this box if you can pick things up and move them without difficulty.

☐ Now go to **question 5**.

Picking up things using your upper body and either arm

Can you pick up and move a half-litre (one pint) carton full of liquid?

☐ No
☐ Yes
☐ It varies

Can you pick up and move a litre (two pint) carton full of liquid?

☐ No
☐ Yes
☐ It varies

Can you pick up and move a large, light object like an empty cardboard box?

☐ No
☐ Yes
☐ It varies

Use this space to tell us more about picking things up and moving them. Tell us why you might not be able to pick things up. If it varies, tell us how.

5. Manual dexterity (using your hands)

Please tick this box if you can use your hands without any difficulty.

☐ Now go to **question 6**.

Can you use either hand to:
- **press a button, such as a telephone keypad**
- **turn the pages of a book**
- **pick up a £1 coin**
- **use a pen or pencil**
- **use a suitable keyboard or mouse?**

☐ Some of these things.
☐ None of these things.
☐ It varies.

Use this space to tell us more. Tell us which of these things you have problems with and why. If it varies, tell us how.

6. Communicating with people

This section asks about how you communicate using speech, writing and typing.

Please tick this box if you can communicate with other people without any difficulty.

☐ Now go to **question 7**.

Can you communicate a simple message to other people such as the presence of something dangerous? This can be by speaking, writing, typing or any other means, but without the help of another person.

☐ No
☐ Yes
☐ It varies

Use this space to tell us more about how you communicate and why you might not be able to communicate with other people. For example, difficulties with speech, writing or typing. If it varies, tell us how.

7. Other people communicating with you

This section asks about how you understand other people by hearing and reading.

Please tick this box if you can understand other people without any difficulty.

☐ Now go to **question 8**.

Can you understand simple messages from other people by hearing or lip reading without the help of another person?
A simple message means things like the location of a fire escape.

☐ No
☐ Yes
☐ It varies

Can you understand simple messages from other people by reading large size print or using Braille?

☐ No
☐ Yes
☐ It varies

Use this space to tell us more. Tell us if you can hear, lip read, read or understand people in another way, or why you might not be able to. Tell us about any aids you use, such as a hearing aid. If it varies, tell us how.

8. Getting around safely

This section asks about visual problems. If you normally use glasses or contact lenses, a guide dog or any other aid, tell us how you manage when you are using them. Please also tell us how well you see in daylight or bright electric light.

Please tick this box if you can get around safely on your own.

☐ Now go to **question 9**.

Can you see to cross the road on your own?

☐ No
☐ Yes
☐ It varies

Can you get around a place that you haven't been to before without help?

☐ No
☐ Yes
☐ It varies

Use this space to tell us more about your eyesight and any problems you have finding your way around safely.

9. Controlling your bowels and bladder and using a collecting device

Please tick this box if you can control your bowels and bladder without any difficulty.

☐ Now go to **question 10**.

Do you have to wash or change your clothes because of difficulty controlling your bladder, bowels or collecting device?
Collecting devices include stoma bags and catheters.

☐ Yes – weekly
☐ Yes – monthly
☐ Yes – less than monthly
☐ Yes – but only if I cannot reach a toilet quickly
☐ No

Use this space to tell us more about controlling your bowels and bladder or managing your collecting device.

Tell us if you experience problems if you cannot reach a toilet quickly.

Tell us how often you need to wash or change your clothes because of soiling, wetting or leakages.

10. Staying conscious when awake

Please tick this box if you do not have any problems staying conscious while awake.

☐ Now go to **question 11**.

While you are awake, how often do you faint or have fits or blackouts?
This includes epileptic fits and absences, and diabetic hypos.

☐ Weekly
☐ Monthly
☐ Less than monthly

Use this space to tell us more.

Part 2: Mental, cognitive and intellectual functions

To answer Yes to any of the following questions, you must be able to do the activity safely, to an acceptable standard, as often as you need to and in a reasonable length of time.

By *mental, cognitive and intellectual functions* we mean things like mental illness, learning difficulties and the effects of head injuries or other brain or neurological conditions.

If you have difficulties completing this section, please refer to the guidance on **page 1**. You can ask a friend, a relative or a representative to help you. Or get in touch with Jobcentre Plus.

11. Learning how to do tasks

Please tick this box if you can learn to do everyday tasks without difficulty.

☐ Now go to **question 12**.

Can you learn how to do a simple task such as setting an alarm clock?

☐ No
☐ Yes
☐ It varies

Can you learn how to do a more complicated task such as using a washing machine?

☐ No
☐ Yes
☐ It varies

Use this space to tell us about any difficulties you have learning to do tasks, and why you find it difficult. If your ability to do tasks varies, tell us how.

Remember – if you need more space you can use the box on **page 17**.

12. Awareness of hazards or danger

Please tick this box if you can stay safe when doing everyday tasks such as boiling water or using sharp objects.

☐ Now go to **question 13**.

Do you need supervision (someone to stay with you) for most of the time to stay safe?

☐ No
☐ Yes
☐ It varies

Use this space to tell us how you cope with danger. Please give us examples of problems you have with doing things safely.

13. Starting and finishing tasks

This section asks about whether you can manage to start and complete daily routines and tasks like getting up, washing and dressing, cooking a meal or going shopping.

Please tick this box if you can manage to do daily tasks without difficulty.

☐ Now go to **question 14**.

Can you manage to plan, start and finish daily tasks?

☐ Never
☐ Sometimes
☐ It varies

Use this space to tell us what difficulties you have doing your daily routines. For example, remembering to do things, planning and organising how to do them, and concentrating to finish them.

Tell us what might make it difficult for you and how often you need other people to help you.

14. Coping with changes

Please tick this box if you can cope with changes to your daily routine.

☐ Now go to **question 15**.

Can you cope with small changes to your routine if you know about them before they happen?
For example, things like having a meal earlier or later than usual, or an appointment time being changed.

☐ No
☐ Yes
☐ It varies

Can you cope with small changes to your routine if they are unexpected?
This means things like your bus or train not running on time, or a friend or carer coming to your house earlier or later than planned.

☐ No
☐ Yes
☐ It varies

Use this space to tell us more about how you cope with change. Explain your problems, and give examples if you can. If it varies, tell us how.

15. Going out

This question is about your ability to cope *mentally* or *emotionally* with going out. If you have *physical* problems which mean you can't go out, you should tell us about this in **Part 1** of the questionnaire.

Please tick this box if you can go out on your own.

☐ Now go to **question 16**.

Can you leave home and go out to places you know?

☐ No
☐ Yes, if someone goes with me
☐ It varies

Can you leave home and go to places you don't know?

☐ No
☐ Yes, if someone goes with me
☐ It varies

Use this space to tell us why you cannot always get to places. Tell us whether you need someone to go with you. Explain your problems, and give examples if you can. If it varies, tell us how.

16. Coping with social situations

By *social situations* we mean things like meeting new people and going to meetings or appointments.

Please tick this box if you can cope with social situations without feeling too anxious or scared.

☐ Now go to **question 17**.

Can you meet people you know without feeling too anxious or scared?

☐ No
☐ Yes
☐ It varies

Can you meet people you don't know without feeling too anxious or scared?

☐ No
☐ Yes
☐ It varies

Use this space to tell us why you find it distressing to meet other people and what makes it difficult. Tell us how often you feel like this. Explain your problems, and give examples if you can. If it varies, tell us how.

Part 2: Mental, cognitive and intellectual functions continued

17. Behaving appropriately

This section asks about whether your behaviour upsets other people.

Please tick this box if your behaviour does not upset other people.

☐ Now go to **question 18**.

How often do you behave in a way which upsets other people?
For example, this might be because you are aggressive or act in an unusual way.

☐ Every day
☐ Often
☐ Occasionally

Use this space to tell us why your behaviour upsets other people and how often this happens. Explain your problems, and give examples if you can. If it varies, tell us how.

Part 3: Eating and drinking

18. Eating and drinking

Can you get food and drink to your mouth without help or prompting from another person?

☐ No
☐ Yes
☐ It varies

Can you chew and swallow food and drink without help or prompting from another person?

☐ No
☐ Yes – now go to **Other information**.
☐ It varies

Use this space to tell us about how you eat and drink, and why you might need help.

Other information

If you need more space to answer any of the questions, please use the space below. If any carers or friends want to add information, they can do it here. We may contact these people for more information to support your claim.

If you are returning this questionnaire late, please tell us why.

Declaration

You may find it helpful to make a photocopy of your reply for future reference.

- **I declare** that I have read and understand the notes at the front of this form, the information I have given on this form is correct and complete and I have included all my income and savings.
- **I understand** that I must report all changes in my circumstances which may affect my entitlement promptly and by failing to do so I may be liable to prosecution or face a financial penalty. I will phone **0345 608 8545**, or write to the office that pays my benefit, to report any change in my circumstances.
- **If I give false** or incomplete information or fail to report changes in my circumstances promptly, I understand that my Employment and Support Allowance may be stopped or reduced and any overpayment may be recovered. In addition, I may be prosecuted or face a financial penalty.
- **I agree** that
  - the Department for Work and Pensions
  - any health care professional advising the Department
  - any organisation with which the Department has a contract for the provision of medical services may ask any of the people or organisations mentioned on this questionnaire for any information which is needed to deal with
  - this claim for benefit
  - any request for this claim to be looked at again

  and that the information may be given to that health care professional or organisation or to the Department or any other government body as permitted by law.
- **I also understand** that the Department may use the information which it has now or may get in the future to decide whether I am entitled to
  - the benefit I am claiming
  - any other benefit I have claimed
  - any other benefit I may claim in the future.
- **I agree** to my doctor or any doctor treating me, being informed about the Secretary of State's determination on
  - limited capability for work
  - limited capability for work-related activity, or
  - both.

You must sign this questionnaire yourself if you can, even if someone else has filled it in for you.

Signature

Please remember to sign the form in pen after printing.

Date

For people filling in this questionnaire for someone else

If you are filling in this questionnaire on behalf of someone else, please tell us some details about yourself.

Your name

Your address

Postcode

Daytime phone number

Code Number

Explain why you are filling in the questionnaire for someone else, which organisation, if any, you represent, or your connection to the person the questionnaire is about.

What to do next

Please make sure that
- you have answered all the questions on this questionnaire that apply to you
- you have signed and dated this questionnaire
- you return the questionnaire in the enclosed envelope. This does not need a stamp.

Tick this box if you are including any medical reports ☐

Would you like us to tell anyone else about this assessment?
For example, support worker, social worker, friends or family. Let us know who this is, their phone number and explain why you would prefer we contacted them instead of you.

How the Department for Work and Pensions collects and uses information

When we collect information about you we may use it for any of our purposes. These include dealing with:

- social security benefits and allowances
- child support
- employment and training
- financial planning for retirement
- occupational and personal pension schemes.

We may get information about you from others for any of our purposes if the law allows us to do so. We may also share information with certain other organisations if the law allows us to.

To find out more about how we use information, visit our website at **www.dwp.gov.uk/privacy-policy** or contact any of our offices.

Cancer treatment – for completion by a healthcare professional which may include a GP, hospital doctor or clinical nurse who is aware of your condition.

The information you provide on this page is important as it will help the Department for Work and Pensions to make a rapid benefit decision for your patient.

This page concerns patients who are having, waiting for or recovering from (post completion of treatment) chemotherapy or radiotherapy.

Please complete the rest of this page. If you have any queries, please visit **www.gov.uk**

Details of cancer diagnosis
Include
- type and site
- stage
- any related diagnoses.

Details of treatment
Include
- regime
- expected duration.

Is your patient:
(Please tick as appropriate.)

☐ awaiting or undergoing chemotherapy or radiotherapy?

☐ recovering (post completion of treatment) from chemotherapy or radiotherapy?

In your opinion, is it likely that the impact of the treatment has or will have work-limiting side effects?

No ☐
Yes ☐ In your opinion are these side effects likely to limit all work?

No ☐
Yes ☐

In your opinion how long would you expect these side effects to last?

Your details:

Name

Qualifications

Signature

Please remember to sign the form in pen after printing.

Surgery stamp, hospital stamp or address details:

Date