

Limited capability for work questionnaire

jobcentreplus

Part of the Department
for Work and Pensions

We need you to fill in this questionnaire if you have claimed or are getting benefits or National Insurance credits.

Please send this questionnaire back by the date given on the enclosed letter. If you are sending the questionnaire in late we need to know why. You can use the space on **page 18** to explain.

If we are able to get enough information about you from this questionnaire, your doctor or the person treating you, we may not need to ask you to attend a face-to-face assessment.

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

How to fill in this questionnaire

This questionnaire asks questions about your physical and mental health. The answers you give in this questionnaire will tell us how your illness or disability affects your ability to work.

This questionnaire may seem long, but do not be put off. Every question has instructions to take you step-by-step to the end of the questionnaire.

You may wish to fill in this questionnaire a bit at a time as it may take some time to complete.

Please use the boxes after each question to tell us in your own words how your illness or disability affects you in doing day-to-day things.

If you want help filling in this questionnaire or any part of it

Ask a friend, relative or representative to help you, or get in touch with Jobcentre Plus. The person from Jobcentre Plus will have a copy of the questionnaire and they will go through the questions you are having trouble with over the phone.

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

They can send you a questionnaire in braille or large print. This questionnaire is also available to download to your computer to fill in. But you must post it back in the envelope we have sent you.

For information about benefits and services visit **www.direct.gov.uk/benefits**. Or call us.

Our phone number is at the top of the letter we sent you with this questionnaire.

About you

Surname

Other names

Title

Address

Date of birth

Letters

Numbers

Letter

National Insurance (NI) number

Face-to-face assessment

You may be asked to attend a face-to-face assessment with a qualified healthcare professional. Atos Healthcare 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.

Daytime phone number

Code

Number

Mobile phone number

Any other number

Code

Number

If you do not understand English, or cannot talk easily in English, do you need an interpreter?

No ☐

Yes ☐

What language do you want to use?

You can bring your own interpreter to the assessment, but they must be over 16.

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.

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

About your illnesses or disabilities

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

Please use the space below to tell us

- **what is your disability, illness, or condition, and**
- **how does it affects you?**

Please also tell us about

- any aids you use, such as a wheelchair or hearing aid
- if you have had a heart attack, stroke, accident or something similar.
Please tell us when this happened.
- anything else you think we should know about your illness or disabilities.

If at any point you need more space, use the space on **page 18**.



About you continued

Details of tablets, medication or special treatment

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

Special treatment could include things like radiotherapy or chemotherapy.

If you will be having chemotherapy, tell us the dates if you know them.

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About your GP

Name of your GP

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Address of your GP

Postcode

GP's phone number

Code	Number
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Does anyone else provide you with care, support or treatment?

Please tell us who they are.

For example:

- physiotherapist
- community psychiatric nurse
- social worker
- occupational therapist
- support worker
- hospital consultant.

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Their address

Postcode

Their phone number

Code	Number
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Other number

Code	Number
------	--------

When was your most recent appointment?

/	/
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If you need more space, please use the box on page 18.

Hospital or clinic treatment

Use this section to tell us about

- any hospital or clinic treatment you are having as an in-patient or out-patient
- any in-patient treatment you have had in the **past 3 months**
- any in-patient treatment you expect to have in the **next 3 months**.

Are you having or awaiting any hospital or clinic treatment?

No ☐

Yes ☐

Were you an in-patient or an out-patient?

In-patient ☐

Out-patient ☐

Are you awaiting chemotherapy treatment?

No ☐

Yes ☐

Were you an in-patient or an out-patient?

In-patient ☐

Out-patient ☐

Tell us when you were or will be in hospital, how often and what for. Please tell us about all your hospital visits here.

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Are you pregnant?

No ☐

Yes ☐

When is the baby due?

	/		/	
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About you continued

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 ☐ Now go to **Part 1**.
Yes ☐

If you have answered **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 ☐
Yes ☐

Tell us where you attend and the dates of your course of treatment.

Part 1 – Physical functions

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.

Can you move at least 50 metres (about 54 yards) before you need to stop? No ☐
To give you an idea about distances: A double-decker bus is about 11 metres long. Yes ☐
It varies ☐

Can you move at least 200 metres (about 220 yards) before you need to stop? No ☐
To give you an idea about distances: A double-decker bus is about 11 metres long. Yes ☐
It varies ☐

Part 1 – Physical functions continued

Use this space to tell us how far you can move and why you might have to stop. For example tiredness or discomfort. 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 ☐

It varies ☐

Now go to question 2.

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 ☐

Can you stay in one place, either standing or sitting, for at least an hour without help from another person?

No ☐

Yes ☐

It varies ☐

This does not mean standing completely still. It includes being able to change position.

Part 1 – Physical functions continued

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, such as pain, discomfort or tiredness. If it varies, tell us how.

3. Reaching

Please tick this box if you can reach up with 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 to reach for something?

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 do things like:

- 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 computer keyboard or computer mouse?

Some of them

☐

None of them

☐

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 looks at 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 with someone you don't know by speaking, writing, typing or any other means without the help of another person?

No

☐

Yes

☐

It varies

☐

Part 1 – Physical functions continued

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 looks at 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 other people – by hearing, lip reading, reading or using a hearing aid – without the help of another person?

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 looks at 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 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

☐

Part 1 – Physical functions continued

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 any problems with your eyesight and how they stop you 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?

Weekly

☐

Monthly

☐

Less often

☐

A collecting device is also known as a *stoma*.

Use this space to tell us more about controlling your bowels and bladder and managing your collecting device. Tell us how often you might need to change your clothes or wash because of soiling, wetting or leakages.

Part 1 – Physical functions continued

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 in Part 2.

While you are awake, how often do you 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

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

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

☐

Part 2 – Mental, cognitive and intellectual functions continued

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

12. Awareness of hazard or danger

Please tick this box if you can keep yourself safe when doing everyday tasks such as cooking.

☐

Now go to question 13.

Do you need supervision
(someone to stay with you) to
keep yourself safe?

Usually

☐

Sometimes

☐

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. Initiating actions

This section is 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 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 change

Please tick this box if you can cope with change 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?

No

☐

Yes

☐

It varies

☐

For example, things like having a meal earlier or later than usual.

Can you cope with small changes to your routine if they are unexpected?

No

☐

Yes

☐

It varies

☐

This means things like appointments being cancelled, or your bus or train not running on time.

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

15. Going out

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 if someone goes
with you?

No

☐

Yes

☐

It
varies

☐

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

Usually

☐

Not very often

☐

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.

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. Now go to question 17.

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

No ☐

Yes ☐

It varies ☐

Can you meet with 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.



17. Behaving appropriately with other people

This section looks at whether your behaviour upsets other people.

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

Please go the **Other Information** section.

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 ☐

Part 2 – Mental, cognitive and intellectual functions continued

Use this space to tell us why your behaviour upsets other people and how often this happens.

Other information

If you need more space to answer questions, please use the space below.

Other information continued

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

Declaration

- **I declare** that the information I have given on this questionnaire is correct and complete as far as I know and believe.
- **I understand** that if I knowingly give information that is incorrect or incomplete, I may be liable to prosecution or other action.
- **I understand** that I must promptly tell the office that pays my benefit of anything that may affect my entitlement to, or the amount of, that benefit.
- **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 servicesmay 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 againand 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

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
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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 we collect and use information

The information we collect about you and how we use it depends mainly on the reason for your business with us. But we may use it for any of the Department's purposes, which include

- social security benefits and allowances
- child support
- employment and training
- private pensions policy, and
- retirement planning.

We may get information from others to check the information you give to us and to improve our services. We may give information to other organisations as the law allows, for example to protect against crime.

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