



Aged Care Workforce Retention Payment - Enquiry Form

ABOUT YOU

Surname	
First and middle name	
Employee No.	
Job Title	
Date of Birth	
Contact No. <i>[During business hours]</i>	
Contact Email	

ABOUT YOUR EMPLOYER

Employer	
Employer No. (or Provider ID)	
Employer ABN	
Employer Address	
Employer Contact <i>[Full name and position held]</i>	

YOUR ENQUIRY

Tell us about your concern	<i>[For example, did you not receive the payment you thought you were owed?]</i>
Have you attached your supporting evidence?	<input type="radio"/> Yes <input type="radio"/> No <i>[You might include some payslips to show you are an employee, or to show the hours you work. If you have any emails or letters from your employer about the Aged Care Workforce Retention Payment, please attach them.]</i>
Have you spoken to your employer about this enquiry?	<input type="radio"/> Yes <input type="radio"/> No <i>[Please note: unless you have a valid reason, you must talk to your employer and try to resolve your enquiry before submitting this form to the Department]</i>
Are you unable to talk to your employer?	<input type="radio"/> Yes <input type="radio"/> Not applicable <i>Please explain why:</i>
Can a Department of Health representative contact your employer about your enquiry?	<input type="radio"/> Yes, you can contact my employer. <input type="radio"/> No, I do not want you to contact my employer. <i>[Please advise why you do not want your employer contacted. The Department will consider any evidence that you have provided and will be limited to making general de-identified enquiries about the payments made by your employer].</i>
I acknowledge the information provided in this form is true and correct. Where I have given my permission, I understand the Department will talk to my employer to resolve this enquiry.	
Signature	
Date	

Send this form to aged.care.workforce.retention.payment.enquiries@health.gov.au