



Application form for Carer's Allowance

How to complete application form for Carer's Allowance.

- Please tear off this page and use as a guide to filling in this form.
- Please read information booklet SW 41 before filling in this application form.
- Please apply for Carer's Allowance as soon as you start caring duties. You could lose payment if you don't.
- Please use BLOCK LETTERS and place a tick (✓) in the relevant boxes.
- Please use black ball point pen.
- Please answer all questions. We will return any form that is incomplete, which will delay processing your application.

- Part 1 - Please fill in all details, following the instructions for the first page. Please sign declaration when form is completed.
- Part 2 to 5 - Please fill in all details.
- Part 6 - Please fill in all relevant details.
- Part 7 - Please tick all boxes that apply to you. Note that you must only include a birth certificate or marriage certificate if you were born or married outside the Republic of Ireland.
- Part 8 - Please have the person or people receiving care fill in Section A. Please have their doctor fill in and sign Section B.

If you need any help to complete this form, please contact your local Social Welfare Office or the Carer's Allowance Section at Longford (043) 45211, ext. 48940.

How to fill in first page of this form

- Print letters and numbers clearly.
- Complete the boxes from left to right starting with the first box.
- Use one character per box.
- Please use black ball point pen.
- Please see example below.

1. Please state your PPS No:

1	2	3	4	5	6	7	T		
---	---	---	---	---	---	---	---	--	--

Title (tick box): Mr. Mrs. Ms. Other

--	--	--	--	--	--	--	--

2. Surname:

M	U	R	P	H	Y														
---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--

3. First name(s):

M	A	R	Y																
---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4. What is your birth surname?

M	C	D	E	R	M	O	T	T											
---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--

5. What is your mother's birth surname?

O	S	U	L	L	I	V	A	N											
---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--

6. What is your address?

1		N	E	W		S	T	R	E	E	T								
		O	L	D		T	O	W	N										
		C	O			D	O	N	E	G	A	L							

7. What is your telephone number?

0	1	7	0	4	3	0	0	0						
L	A	N	D	L	I	N	E							
0	8	6	1	2	3	4	5	6	7					
M	O	B	I	L	E									

8. What is your email address?

M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E		

9. What is your date of birth? (Please attach your birth certificate if born outside the Republic of Ireland)

2	8			0	2			1	9	7	0								
D	D			M	M			Y	Y	Y	Y								

10. What country were you born in?

I	R	E	L	A	N	D													
---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--

11. Are you? Single Married Separated Remarried
Widowed Cohabiting Divorced

SAMPLE



Application form for Carer's Allowance

Part 1

Your own details

- Please state your PPS No:
- Title (tick box): Mr. Mrs. Ms. Other
- Surname:
- First name(s):
- What is your birth surname?
- What is your mother's birth surname?
- What is your address?
- What is your telephone number?

L A N D L I N E

M O B I L E
- What is your email address?
- What is your date of birth? (Please attach your birth certificate if born outside the Republic of Ireland)

D D M M Y Y Y Y
- What country were you born in?
- Are you? Single Married Separated Remarried
Widowed Cohabiting Divorced

Declaration by you

All the information I have given on this form is accurate. I will tell the Department as soon as possible if my means or circumstances change.

I declare the person(s) named in Part 6 require(s) full-time care and attention. I am the person providing full-time care and attention.

If you cannot sign your name, make a mark, such as an X, and have a witness sign their name beside it.

Signature

(NOT block letters)

Date:

D D

M M

Y Y Y Y

Warning: If you make a false statement or you withhold information, you may face a fine, a prison sentence or both.

12. When did you get married?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

13. Have you ever claimed Carer's Allowance before?

Yes No

If 'Yes', please state:

Your claim or reference number:

Your address when you claimed:

14. Are you getting any payment from this Department or the Health Service Executive (for example, Supplementary Welfare Allowance)?

Yes No

If 'Yes', please state:

Name of payment:

Amount:

€ a week

Your claim or reference number:

If you are getting Jobseeker's Benefit or Allowance, state the name of the local Social Welfare Office:

Have you had a social welfare means test in the last 12 months?

Yes No

15. Is anyone claiming for you as a qualified child or adult on their payment from this Department or the Health Service Executive?

Yes No

If 'Yes', please state:

Name of payment:

Person's name:

Amount:

€ a week

Their claim or reference number:

16. Are you getting a social security payment from another country?

Yes

No

If 'Yes', please state:

Amount of payment you get:

€ _____ a week

Please attach a recent payslip or letter from the social security agency confirming this amount.

Name of country that pays you:

17. Are you getting an occupational or private pension?

Yes

No

If 'Yes', please state:

Who pays this pension:

Amount you get:

€ _____ a week

Please attach recent payslip or letter from company paying you to confirm this amount.

18. Are you taking part in any training course or further education?

Yes

No

If 'Yes', please attach a letter from college giving details of your course and the hours you attend.

19. (a) Are you employed at present?

Yes

No

(b) Are you self-employed (including farming) at present?

Yes

No

If 'Yes' to (a) or (b) above, please state:

When you started work:

Type of work you do:

Where you work:

Name and address of employer:

Amount of gross earnings:

€ _____ a week

Please attach evidence such as a current payslip, P60, P45 or a statement from your accountant, if self-employed.

20. (a) If you are working, do you intend to give up this work to provide full-time care and attention for the person(s) named in Part 6?

Yes No

If 'Yes', please attach your P45, if you have already stopped working.

(b) You can work for up to 15 hours a week outside the home. Do you intend to....?

(i) remain at work for up to 15 hours a week

* Yes No

or

(ii) return to work for up to 15 hours a week

* Yes No

* Please get a statement from your employer and attach it to this application. The statement should show the number of hours worked or to be worked and the wages earned. If you are reducing your working hours to 15, the statement should include the date on which this takes place. If you are self-employed, please attach a note showing type of work, proposed number of hours and income.

21. a) Have you savings or accounts in a bank, post office, building society, credit union or any other financial institution?

Yes No

If 'Yes', please attach a statement for each account, showing the current balance.

b) Have you any savings in cash?

Yes No

If 'Yes', please state:

Amount:

€

22. Have you any investments or shares?

Yes No

If 'Yes', please attach a statement giving the current market value of the shares.

23. Have you any property (apart from your own home)?

Yes No

If 'Yes', please state:

Type of property:

Address:

Current market value:

€

24. If you have moved from your home to live with the person you are caring for, please state if your home is rented, occupied by other people or otherwise being used:

25. Have you sold or transferred any property or business recently?

 Yes

 No

If 'Yes', please give details:

Please attach a copy of the Deed of Transfer.

If you have recently sold your home to buy another, please attach a note outlining the circumstances.

26. (a) Do you own a farm or land?

 Yes

 No

(b) Do you occupy a farm owned by any other person, for example your parent, brother, sister, aunt or uncle?

 Yes

 No

Has this farm or land ever been assessed for any payment from this Department?

 Yes

 No

'Assessed' means you gave us details about the farm or land when you applied for another payment.

If 'Yes', please state:

Name of payment:

Date assessed:

<input type="text"/>	<input type="text"/>	Day	<input type="text"/>	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	----------------------	-----	----------------------	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

27. Are you getting maintenance?

 Yes

 No

If 'Yes', does a formal Maintenance Order or Separation Agreement exist?

 Yes

 No

Maintenance for you:

 €2

 a week or month*

Maintenance for children:

 €2

 a week or month*

*delete as appropriate

Please attach a copy of your Maintenance Order or Separation Agreement, if you have one. If you do not have one, please attach a note describing how maintenance is paid to you.

Part 2

Your spouse's or partner's details

28. What is your spouse's or partner's name?

Surname
First name(s)

29. What is their birth surname?

30. What is their address?

Address

31. What is their telephone number?

Landline no.	Mobile no.
--------------	------------

32. What is their date of birth?

<input type="text"/>	<input type="text"/>	Day	<input type="text"/>	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	----------------------	-----	----------------------	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

33. In what country were they born?

34. What is their nationality?

35. What is their PPS No.?

Figures							Letter(s)	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

36. Are they getting any payment from this Department or the Health Service Executive (for example Supplementary Welfare Allowance)?

Yes No

If 'Yes', please state:

Name of payment:

Amount:

€	<input type="text"/>	a week
---	----------------------	--------

Their claim or reference number:

If claiming Jobseeker's Benefit or Allowance, state name of local Social Welfare Office:

37. Is anyone claiming for your spouse or partner as a qualified adult on their payment from this Department or the Health Service Executive?

Yes No

If 'Yes', please state:

Name of payment:

Person's name:

Amount:

€	<input type="text"/>	a week
---	----------------------	--------

Their claim or reference number:

38. Is your spouse or partner getting a social security payment from another country?

 Yes

 No

If 'Yes', please state:

Amount of payment they get:

€ _____ a week

Please attach a recent payslip or letter from the social security agency to confirm this amount.

Name of country that pays them:

39. Is your spouse or partner getting an occupational or private pension?

 Yes

 No

If 'Yes', please state:

Who pays this pension:

Amount they get:

€ _____ a week

Please attach a recent payslip or letter from the company paying them to confirm this amount.

40. (a) Is your spouse or partner employed at present? or

(b) self-employed (including farming) at present?

If 'Yes' to (a) or (b) above, please state:

When they started work:

Type of work they do:

Where they work:

Name and address of employer:

Please attach evidence such as a current payslip, P60, P45 or a statement from their accountant, if self-employed.

Amount of earnings:

€ _____ a week

41. Has your spouse or partner savings or accounts in a bank, post office, building society, credit union or any other financial institution?

 Yes

 No

If 'Yes', please attach a statement for each account, showing the current balance.

Has your spouse or partner any savings in cash?

 Yes

 No

If 'Yes', please state amount:

€ _____

42. Has your spouse or partner any investments or shares?

Yes No

If 'Yes', please attach a statement giving the current market value of the shares.

43. Has your spouse or partner any property (apart from their own home)?

Yes No

If 'Yes', please state:

Type of property:

Address:

Current market value:

€

44. Has your spouse or partner sold or transferred any property or business recently?

Yes No

If 'Yes' please give details:

Please attach a copy of the Deed of Transfer.

If they have recently sold their home to buy another, please attach a note outlining the circumstances.

45.a) Does your spouse or partner own a farm or land?

Yes No

b) Does your spouse or partner occupy a farm owned by any other person, for example a parent, brother, sister, aunt or uncle?

Yes No

Has this farm or land ever been assessed for any payment from this Department?

Yes No

'Assessed' means your spouse or partner gave us details about the farm or land when they applied for another payment.

If 'Yes', please state:

Name of payment:

Date assessed:

Day Month Year

46. Do you have any children under age 18 or between 18 and 22 in full-time education?

 Yes

 No

If 'Yes', please give details here of each child you are maintaining, starting with the eldest child, indicating whether or not they live with you.

Attach a letter from the school or college for any child aged between 18 and 22 to confirm that they are in full-time education.

Child's full name	Date of birth			PPS No.	Relationship to you	Is this child living with you?
	Day	Month	Year			

Note:

A qualified child need not be your own child. If you maintain a child and get Child Benefit for them, you may apply for a Qualified Child Increase for them.

47. Does each child live with you?

 Yes

 No

Qualified children who live in rented accommodation while at college are regarded as living with you.

If 'No', please state:

Name of the person(s) with whom the child(ren) live(s):

Address:

Amount of maintenance paid by you, if any:

€	a week or month*
---	------------------

*delete as appropriate

This section must be completed by all applicants.

Habitual residence is a condition that you must satisfy to qualify for Carer's Allowance. See SW 108 for more information about habitual residence.

48. In what country were you born?

49. What is your nationality?

50. When did you come to Ireland?

<input type="text"/>	<input type="text"/>	Day	<input type="text"/>	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	----------------------	-----	----------------------	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

51. Have you lived in the *Common Travel Area all of your life, including the last 2 years? If 'Yes', please state where you lived in the Common Travel Area in the table below.

Yes No

If 'No', please complete questions 52-55.

Country	From	To	Why you lived there

Note

*The Common Travel Area is Ireland, Great Britain, the Isle of Man and the Channel Islands. You can spend brief periods on short holidays, studying or travelling outside the Common Travel Area and still be habitually resident here.

If you lived in Northern Ireland, Great Britain, the Isle of Man or the Channel Islands, please provide proof of residence. Residency may be verified by producing a passport or identity card and one or more of the following: employment records such as P45 or P60; bank statements; details of benefit payments; utility bills; rent or mortgage agreements or receipts for local authority charges.

52. Have you lived at the same address for the last 2 years?

Yes No

If 'No', please give details of previous addresses:

Last address
From
To

Previous address
From
To

53. Have you lived continuously in Ireland since the day you arrived? Yes No

54. Does any of your close family, for example parent, brother, sister or child, live in Ireland? Yes No

If 'Yes', please give their details here:

Name	Address	Date of birth			Relationship to you	When they came to Ireland
		Day	Month	Year		

55. Have you ever made an application for refugee status? Yes No

If 'Yes', please answer both questions 55(a) and 55(b).

(a) Are you awaiting a decision on an application for refugee status? Yes No

(b) Have you been granted refugee status or leave to remain in the State? Yes No

If 'Yes' to (b), please provide copies of all relevant documentation from the Department of Justice, Equality and Law Reform.

For Departmental use only

HRC satisfied HRC not satisfied HRC 1 issued

You can get Carer's Allowance direct to your current or deposit savings account in a financial institution or at your local post office.

Direct payment to your account in a financial institution

Name of financial institution:

Address:

Name of account holder:

The account must be in your name or jointly held by you.

Type of account:

Sort code (you can get this from your branch):

--	--	--	--	--	--

Account number (8 digits):

--	--	--	--	--	--	--	--

Post office payment

Name of post office:

Address:

Person 1

56. What is their full name?

Surname
First name(s)

57. What is their birth surname?

--

58. Where do they live?

59. What is their date of birth?

Day		Month		Year		

60. What is their PPS No.?

Figures							Letter(s)	

61. What type of payment are they getting, if any?

Please name only the social welfare payment(s) from Ireland or another country.

62. What is their claim or reference number?

--

63.a) What date did caring start?

--

63.b) Has anyone paid you for looking after this person since this date?

Yes No

64. Is Domiciliary Care Allowance being paid for them?

Yes No

If so, please supply evidence of payment from the Health Service Executive.

If not, have you or anyone applied for Domiciliary Care Allowance for them?

Yes No

65.a) Is the person named at Question 56 attending a day care or rehabilitative centre?

Yes No

65.b) Does the person stay overnight in any of these centres?

Yes No

Person 1 continued

Note: A person is regarded as receiving full-time care while attending a day care centre during the daytime only. If the person stays overnight at the care facility, you must state this clearly.

If 'Yes' to (a) or (b) above, please state:

Name of centre:

Address:

Telephone number of centre:

Code
Number

Number of days they attend:

	days a week
--	-------------

Number of hours:

	hours a day
--	-------------

Please attach letter of confirmation from day care centre.

66. Does the person you are caring for live with you?

Yes No

If 'No', please state:

How many hours a week do you provide care:

	hours a week
--	--------------

Distance between households:

--

If there is a direct phone link?

Yes No

If 'No', is there any other type of direct link?

Yes No

Details of direct link:

Note

Please answer the above question fully if the person you are caring for does not live with you.

If you are caring for one person only, please go to Part 7

Person 2 (if applicable)

67. What is their full name?

Surname
First name(s)

68. What is their birth surname?

--

69. Where do they live?

70. What is their date of birth?

Day		Month		Year		

71. What is their PPS No.?

Figures							Letter(s)	

72. What type of payment are they getting, if any?

--

Please name only the social welfare payment(s) from Ireland or another country.

73. What is their claim or reference number?

--

74.a) What date did caring start?

--

74.b) Has anyone paid you for looking after this person since this date?

Yes No

75. Is Domiciliary Care Allowance being paid for them?

Yes No

If so, please supply evidence of payment from the Health Service Executive.

If not, have you or anyone applied for Domiciliary Care Allowance for them?

Yes No

76.a) Is the person named at question 67 attending a day care or rehabilitative centre?

Yes No

76.b) Does the person stay overnight in any of these centres?

Yes No

Person 2 continued (if applicable)

Note: A person is regarded as receiving full-time care while attending a day care centre during the daytime only. If the person stays overnight at the care facility, you must state this clearly.

If 'Yes' to (a) or (b) above, please state:

Name of centre:

Address:

Telephone number of centre:

Code
Number

Number of days they attend:

	days a week
--	-------------

Number of hours:

	hours a day
--	-------------

(Please attach letter of confirmation from day care centre.)

77. Does the person you are caring for live with you?

Yes No

If 'No', please state:

How many hours a week do you provide care:

	hours a week
--	--------------

Distance between households:

--

If there is a direct phone link?

Yes No

If 'No', is there any other type of direct link?

Yes No

Details of direct link:

Note

If you are caring for more than 2 people, you may get Respite Care Grant for them. Please fill in CR2 and send it to Carer's Allowance Section, Social Welfare Services Office, Ballinalee Road, Longford. You can get form CR2 online at www.welfare.ie, by telephoning the Department's LoCall Leaflet Request Line at 1890 20 23 25 or from your local Social Welfare Office.

If you do not send in all certificates and documents your application can not be processed and your payment will be delayed. If you are not sending in certain certificates or documents, please enclose a note stating that they will follow later. There is no need to send in certificates if the birth or marriage occurred within the Republic of Ireland.

If sending certificates or documents at a later date, please remember to state your full name, present address and your PPS No. or claim number on all correspondence. You will get your claim number shortly after you apply.

1. Have you answered all the questions in this form, including those for your spouse or partner? Yes No
2. Have you ticked all the relevant answer boxes? Yes No
3. Have you enclosed the following certificates and documents with your application?
 - Your birth certificate (if born outside Republic of Ireland) Yes No
 - Your marriage certificate (if married outside Republic of Ireland) Yes No
 - Certificate of Separation or Divorce (if relevant) Yes No
 - Recent advice slip from the office issuing payment(s) from abroad Yes No
 - Confirmation of Domiciliary Care Allowance (if relevant) Yes No
 - Current payslip Yes No
 - Your P60, P45 or a statement from accountant, if self-employed Yes No
 - Statement(s) from employer or college Yes No
 - Statement(s) from financial institutions Yes No
 - Payslip or letter, if getting an occupational or private pension Yes No

Please remember to sign the declaration in Part 1

Send the completed application form and other documents to:

Carer's Allowance Section
 Social Welfare Services Office
 Government Buildings
 Ballinalee Road
 Longford

Telephone: Longford (043) 45211, ext. 48940
 Dublin (01) 704 3000

Important: You could lose payment if you do not apply as soon as you start caring.

Data Protection And Freedom of Information

We, the Department of Social and Family Affairs, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies in accordance with law. We are responsible for it under the Data Protection Act and Freedom of Information Act

Explanations and terms used in this form are intended as a guide only and do not purport to be a legal interpretation.



Note to carer

Important

You do not need to send a medical report at this stage for a person for whom Domiciliary Care Allowance is being paid by the Health Service Executive.

The following medical forms are in two parts. **Have Section A completed and signed by the person(s) being cared for.**

You must then pass the entire medical form to the doctor of the person being cared for. The doctor may return the form to you in a sealed envelope to keep their patient's medical details confidential.

Please make sure you return the medical form along with your application.

Section A (Person 1)

Authorisation

I need **full-time care** and **attention** and the person named in Part 1 is providing full-time care and attention to me. I will tell the Department of Social and Family Affairs if this changes.

I permit my doctor to provide you, the Department of Social and Family Affairs, with medical information that you may need for this application for Carer's Allowance.

I understand that I may need to attend a medical exam from time to time and that my right to care under the Carer's Allowance scheme may be reviewed at any time.

Your signature or mark

Date

(not block letters)

If you cannot sign, make a mark and have it witnessed. A witness cannot be the carer or a member of the carer's household.

Signature of witness

Date

(not block letters)

Note

In signing the authorisation above, you allow your doctor to give us the medical information we need to decide if you qualify for care under the Carer's Allowance scheme.

One of our Medical Assessors will review the medical information and will treat it in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

Section B

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess if they qualify for care under the Carer's Allowance scheme, please complete the medical report overleaf. The medical information provided will be reviewed by one of our Medical Assessors, who will treat it in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

You can get a special fee for completing and returning this report. To ensure payment, please enter your panel number in the box provided.

For reasons of medical confidentiality, you may wish the medical evidence for your patient to be passed to the Department's Chief Medical Adviser, without potential inspection by other people. If you have any questions on this matter, please contact the Department at the telephone number given below.

The format of this medical report has been agreed between the IMO and this Department. It is standard for all sickness schemes. However, Carer's Allowance differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with a disability.

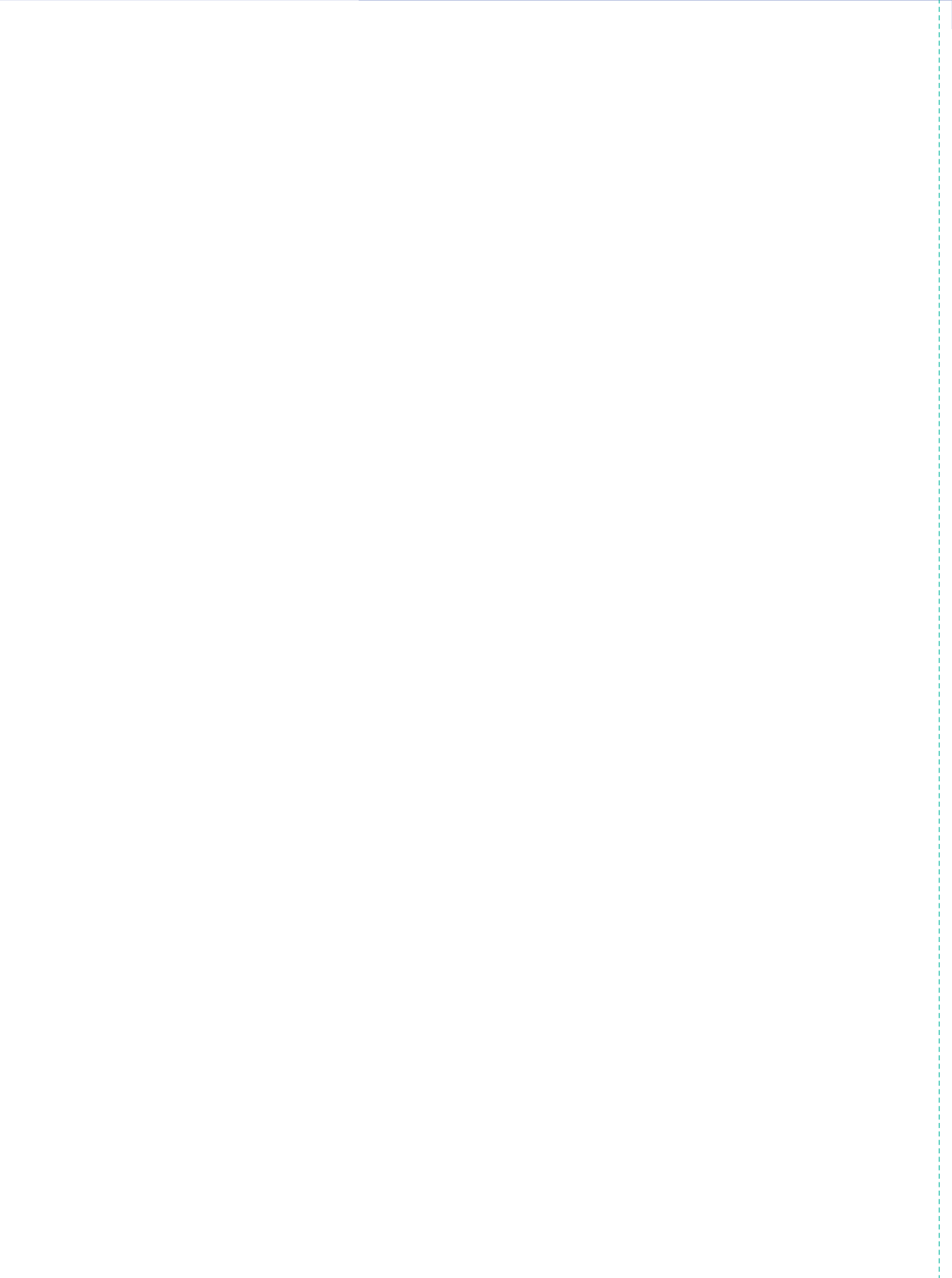
If you feel that a bare outline of the disability does not adequately address the need for care, please feel free to add any additional observations on the caring situation at Question 6. You may also attach copies of any reports or other documents that you feel demonstrate the need for full-time care.

If you have any queries, please contact the **Carer's Allowance Section** directly at **(043) 45211, ext. 48940**.

Note:

The carer should already have filled Parts 1 and 6 of the application form. The person(s) being cared for must have completed Section A of this medical report section.

THE COMPLETED MEDICAL REPORT FORM SHOULD BE RETURNED BY THE DOCTOR TO THE CARER WHO WILL SEND IT, ALONG WITH HIS/HER APPLICATION FORM, TO THE CARER'S ALLOWANCE SECTION.



Section B - Person 1

1. Patient's full name and address:

Name
Address

Date of birth:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

Your patient since:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

2. Diagnosis (use BLOCK LETTERS):

3. Date incapacity started:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

4. How long do you expect this incapacity to continue?

<input type="checkbox"/> less than 12 months	<input type="checkbox"/> 12-24 months
<input type="checkbox"/> 24-48 months	<input type="checkbox"/> indefinitely

5. If the answer to any of the questions listed below is Yes (Y), please give details in boxes provided.

• Hospital admissions:

Y/N

Date of most recent admission:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

Date of discharge:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

• Attending a specialist:

Y/N

• On medication:

Y/N

• Other treatment:

Y/N

• Pregnant:

Y/N

• If 'Y', give EDD:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	----------------------	------

6. If you have any additional information in this case, give details here:

Section B - Person 1

7. Indicate the degree to which your patient's condition has affected their ability in each of the following areas.

	Normal	Mild	Moderate	Severe	Profound
Mental health →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning/Intelligence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness/Seizures →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Co-ordination →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual dexterity →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Kneeling/Squatting →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A medical exam by one of our medical assessors may be required to determine eligibility under the Carer's Allowance scheme.

Is your patient fit to attend a medical exam? Yes No

If 'No', give details here:

DSFA Panel Number:

Address:

Doctor's Official Stamp

Doctor's signature

Date

(not block letters)

Section A (Person 2)

Authorisation

I need **full-time care and attention** and the person named in Part 1 is providing full-time care and attention to me. I will tell the Department of Social and Family Affairs if this changes.

I permit my doctor to provide you, the Department of Social and Family Affairs, with medical information that you may need for this application for Carer's Allowance.

I understand that I may need to attend a medical exam from time to time and that my right to care under the Carer's Allowance scheme may be reviewed at any time.

Your signature or mark

Date

(not block letters)

If you cannot sign, make a mark and have it witnessed. A witness cannot be the carer or a member of the carer's household.

Signature of witness

Date

(not block letters)

Note

In signing the authorisation above, you allow your doctor to give us the medical information that we need to decide if you qualify for care under the Carer's Allowance scheme.

One of our Medical Assessors will review the medical information and will treat it in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

Section B

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess if they qualify for care under the Carer's Allowance scheme, please complete the medical report overleaf. The medical information provided will be reviewed by one of our Medical Assessors, who will treat it in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

You can get a special fee for completing and returning this report. To ensure payment, please enter your panel number in the box provided.

For reasons of medical confidentiality, you may wish the medical evidence for your patient to be passed to the Department's Chief Medical Adviser, without potential inspection by other people. If you have any questions on this matter, please contact the Department at the telephone number given below.

The format of this medical report has been agreed between the IMO and this Department. It is standard for all sickness schemes. However, Carer's Allowance differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with a disability.

If you feel that a bare outline of the disability does not adequately address the need for care, please feel free to add any additional observations on the caring situation at Question 6. You may also attach copies of any reports or other documents that you feel demonstrate the need for full-time care.

If you have any queries, please contact the **Carer's Allowance Section** directly at **(043) 45211, ext. 48940**.

Note:

The carer should already have filled Part 1 and 6 of the application form. The person(s) being cared for must have completed Section A of this medical report section.

THE COMPLETED MEDICAL REPORT FORM SHOULD BE RETURNED BY THE DOCTOR TO THE CARER WHO WILL SEND IT, ALONG WITH HIS/HER APPLICATION FORM, TO THE CARER'S ALLOWANCE SECTION.

Section B - Person 2

1. Patient's full name and address:

Name
Address

Date of birth:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	------

Your patient since:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	------

2. Diagnosis (use BLOCK LETTERS):

3. Date incapacity started:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	------

4. How long do you expect this incapacity to continue?

<input type="checkbox"/>	less than 12 months	<input type="checkbox"/>	12-24 months
<input type="checkbox"/>	24-48 months	<input type="checkbox"/>	indefinitely

5. If the answer to any of the questions listed below is Yes (Y), please give details in boxes provided

• Hospital admissions:

Y/N

Date of most recent admission:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	------

Date of discharge:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	------

• Attending a specialist:

Y/N

• On medication:

Y/N

• Other treatment:

Y/N

• Pregnant:

Y/N

• If 'Y', give EDD:

<input type="text"/>	Day	<input type="text"/>	Month	<input type="text"/>	<input type="text"/>	<input type="text"/>	Year
----------------------	-----	----------------------	-------	----------------------	----------------------	----------------------	------

6. If you have any additional information in this case, give details here:

Section B - Person 2

7. Indicate the degree to which your patient's condition has affected their ability in each of the following areas.

	Normal	Mild	Moderate	Severe	Profound
Mental health →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning/Intelligence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness/Seizures →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Co-ordination →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual dexterity →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Kneeling/Squatting →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A medical exam by one of our medical assessors may be required to determine eligibility under the Carer's Allowance scheme.

Is the care recipient fit to attend a medical exam? Yes No

If 'No' give details here:

DSFA Panel Number:

Address:

Doctor's Official Stamp

Doctor's signature

Date

(not block letters)



Data Protection and Freedom of Information

We, the Department of Social and Family Affairs, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies in accordance with law. We are responsible for your information under the Data Protection Act and Freedom of Information Act.

Explanations and terms used in this form are intended as a guide only and do not purport to be a legal interpretation.