



Application form for **Carer's Benefit**

How to complete this application form.

Please tear off this page and use as a guide to filling in this form.

- Please use **BLACK** ball point pen.
- Please use **BLOCK LETTERS** and place an X in the relevant boxes.
- Please answer **all questions** that apply to you.
- You need a Personal Public Service Number (PPS Number) before you apply.

If you do not have a spouse, civil partner or cohabitant:

If you do not have a spouse, civil partner or cohabitant, fill in **Parts 1, 2, 3, 4, 5 and 8**. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

If you have a spouse, civil partner or cohabitant:

If you have a spouse, civil partner or cohabitant, fill in **Part 1, 2, 3, 4, 5, 6, 7 and 8**. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

Carer:

Please complete **Section A** in **Part 10** of the medical report and get the person you are caring for to sign **Section A** in **Part 10** of the medical report.

Doctor:

Please fill in **Section B** in **Part 10** of the medical report. Please make sure you sign and stamp this part of the form.

If you need any help to complete this form, please contact your local Social Welfare Office or Citizens Information Centre.

For more information, log on to **www.gov.ie**.

You should apply for Carer's Benefit as soon as you start caring for someone. You could lose payment if you don't.

How to fill in first page of this form

To help us in processing your application:

- Print letters and numbers clearly.
- Use one box for each character (letter or number).

Please see example below.

1. Your PPS Number:

1	2	3	4	5	6	7	T	
---	---	---	---	---	---	---	---	--
2. Title: (insert an **X** or specify) Mr Mrs Ms Other

--	--	--	--	--	--	--	--
3. Surname:

M	U	R	P	H	Y														
---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--
4. First name(s):

M	A	U	R	E	E	N													
---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--
5. Your first name as it appears on your birth certificate:

M	A	R	Y																
---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--
6. Birth surname:

M	C	D	E	R	M	O	T	T											
---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--
7. Your date of birth:

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

Your contact details

8. Your address:

1		N	E	W		S	T	R	E	E	T								
O	L	D		T	O	W	N												
D	O	N	E	G	A	L		T	O	W	N								
County	D	O	N	E	G	A	L												
Eircode	A	1	2	B	1	2	3												
9. Your telephone number:

O	N	E		N	U	M	B	E	R		P	E	R		B	O	X		
---	---	---	--	---	---	---	---	---	---	--	---	---	---	--	---	---	---	--	--
10. Your email address:

O	N	E		C	H	A	R	A	C	T	E	R		P	E	R			
B	O	X																	

SAMPLE

Part 2 continued

Your work and claim details

17. When did you start working with your current employer (if relevant)?

D	D	M	M	Y	Y	Y	Y		

18. When did you start caring?

D	D	M	M	Y	Y	Y	Y		

19. Do you have a second employer?

Yes No

If you have resigned from employment, please enclose your P45.

20. If you are currently employed, when do you intend to take leave for caring purposes?

D	D	M	M	Y	Y	Y	Y		

21. Are you self-employed?

Yes No

Part 3

Your payment details

You can get your payment at your local post office or direct to your current, deposit or savings account in a financial institution. Please complete one option below.

Post Office

Post Office address:

22. Do you have a Social Services Card?

Yes No

Financial Institution

You will find the following details printed on statements from your financial institution.

Name of financial institution:

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

Address of financial institution:

Sort code:

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

Account number:

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

Bank Identifier Code (BIC):

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

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

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

Name 2 (if any):

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

Part 4

To be completed by your most recent or current employer

Important note: Your current or last employer must complete this part even if you have left work. A P60 or P45 is not enough.

23. Please state, your employee's:

Surname:

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

First name(s):

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

PPS Number:

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

24. Is this employment:

Part-time

Full-time

25. (a) Please state number of hours worked by employee before commencing carer's leave:

Hours:

--	--

 a week

or

Hours:

--	--

 a fortnight

25. (b) If the employee is awarded carer's leave, please state:

Date they intend to leave work:

From:

--	--

--	--

--	--	--	--

To:

--	--

--	--

--	--	--	--

D D

M M

Y Y Y Y

Date they intend to reduce their hours:

From:

--	--

--	--

--	--	--	--

To:

--	--

--	--

--	--	--	--

D D

M M

Y Y Y Y

If your employee is reducing their hours, please state:

Hours reduced: From:

--	--

 a week

--	--

 a fortnight

To:

--	--

 a week **or**

--	--

 a fortnight

New Gross Earnings (excluding superannuation): €

--

,

--	--	--

.

--	--

 a week

Tax deduction: €

--

,

--	--	--

.

--	--

 a week

Employee's PRSI deducted: €

--

,

--	--	--

.

--	--

 a week

Public Service Pension Levy: €

--

,

--	--	--

.

--	--

 a week

Universal Social Charge: €

--

,

--	--	--

.

--	--

 a week

Employer's: Please note this section continues on the next page.

Part 4 continued

To be completed by your most recent or current employer

26. Please state type of leave your employee intends to take or has taken:

- Carer's leave
 Other (please specify below)

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

27. Please answer (a) or (b) below:

27. (a) Please give details of employee's PRSI record for the 12 month period immediately before their carer's leave starts:

Period of employment: From:

--	--

--	--

--	--	--	--

 Number of weeks:

--	--

 PRSI class:

--

To:

--	--

--	--

--	--	--	--

--	--

--

D D M M Y Y Y Y

or

27. (b) Please give details of employee's PRSI record immediately before they left your employment:

Period of employment: From:

--	--

--	--

--	--	--	--

 Number of weeks:

--	--

 PRSI class:

--

To:

--	--

--	--

--	--	--	--

--	--

--

D D M M Y Y Y Y

28. If less than 52 weeks applies, state the number of weeks the employee worked at 16 hours or more in the previous 26 weeks (please note the relevant 26 week period will be the last 26 weeks actually worked by the employee):

--	--

Signed by or for employer

--

Signature (not block letters)

--

Position in company or organisation

<p>Employer's official stamp</p>

Date:

--	--

--	--

2	0		
---	---	--	--

D D M M Y Y Y Y

Employer's registered number:

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

Employer's telephone number:

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

 MOBILE

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

 LANDLINE

Employer's email address:

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

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

Warning: If you make a false or misleading statement to obtain Carer's Benefit for another person, you may face a fine, a prison sentence or both.

Part 5

Details of your children

29. How many children do you wish to claim for?

under age 18

age 18 - 22 in full-time education*

***You must attach written confirmation from the school or college for the children aged 18 - 22.**

Please state child's:

Surname:

First name(s):

PPS Number:

Date of birth:

D D M M Y Y Y Y

Are they living with you?

 Yes No

Surname:

First name(s):

PPS Number:

Date of birth:

D D M M Y Y Y Y

Are they living with you?

 Yes No

Surname:

First name(s):

PPS Number:

Date of birth:

D D M M Y Y Y Y

Are they living with you?

 Yes No

Surname:

First name(s):

PPS Number:

Date of birth:

D D M M Y Y Y Y

Are they living with you?

 Yes No

Surname:

First name(s):

PPS Number:

Date of birth:

D D M M Y Y Y Y

Are they living with you?

 Yes No

Part 6

Your spouses', civil partner's or cohabitant's details

30. Their PPS Number:

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

31. Title: (insert an X or specify)

Mr Mrs Ms Other

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

32. Their surname:

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

33. Their first name(s):

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

34. Their birth surname:

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

35. Their date of birth:

D	D	M	M	Y	Y	Y	Y		

36. Their address:

Only answer this question if you are married or in a civil partnership and do not live together.

Part 7

Your spouse's, civil partner's or cohabitant's work and claim details

Please complete this section for your spouse, civil partner or cohabitant.

37. If they are getting any payment from this Department or the Health Service Executive (for example, Supplementary Welfare Allowance), please state:

Name of payment:

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

Their claim or reference number:

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

Amount:

€

--	--

,

--	--	--	--

.

--	--

 a week

Please attach the most recent payslip or letter from the Social Security Agency confirming the above amount.

38. If they are getting any other pension or allowance, please state:

Who pays this pension:

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

Their claim or reference number:

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

Amount:

€

--	--

,

--	--	--	--

.

--	--

 a week

Please attach the most recent payslip or letter from the people who pay them confirming the above amount.

39. If they are paying maintenance, please state:

Amount:

€

--	--

,

--	--	--	--

.

--	--

 a week

40. If they are receiving maintenance, please state:

Amount:

€

--	--

,

--	--	--	--

.

--	--

 a week

41. Their PPS Number:

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

42. Title: (insert an X or specify)

Mr Mrs Ms Other

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

43. Their surname:

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

44. Their first name(s):

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

45. Their birth surname:

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

46. Their date of birth:

D	D	M	M	Y	Y	Y	Y								

47. Their address:

48. Their mother's birth surname:

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

49. What is your relationship to the person you are caring for?

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

50. (a) Date you started caring for this person:

D	D	M	M	Y	Y	Y	Y							

50. (b) Has anyone paid you to look after this person since this date?

Yes No

51. Are they getting Domiciliary Care Allowance?

Yes No

52. If **No**, have you or anyone applied for Domiciliary Care Allowance for them?

Yes No

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

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

54. Is the person named above attending a day care or rehabilitative centre?

Yes No

55. Do they stay overnight in any of these centres?

Yes No

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.

Has your employer completed Part 4?

Have you enclosed the following?

— **Letter from school or college**

(if you have child(ren) aged between 18 and 22 who are in full-time education)

— **A statement from accountant if you are self-employed**

If you were born, married or entered into a civil partnership or a civil union outside the Republic of Ireland:

— **Your birth certificate**

— **Your marriage certificate or civil partnership or civil union registration certificate**

— **Your children's birth certificate(s)** (if applying for an increase for them)

Note: No birth certificate is needed if you are already getting Child Benefit.

Original certificates only.

If your form is not fully complete or the documents required are not enclosed there will be a delay in deciding your claim for Carer's Benefit.

Please remember to sign the declaration in Part 1.

Send the completed application form and other documents to:

Carer's Benefit Section

Social Welfare Services

Government Buildings

Ballinalee Road

Longford

N39 E4EO

LoCall: 1890 92 77 70 (from Ireland only)

Telephone: + 353 43 334 0000 (from Northern Ireland or overseas)

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

Note

The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments and benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at www.gov.ie/dsp/privacystatement or in hard copy.

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



Note to carer

Important

You do not need to send a medical report at this stage for a child for whom Domiciliary Care Allowance is being paid by this Department.

The following medical forms are in two parts. **Have Section A completed and signed by the person 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.



Medical Report for Carer's Benefit

Part 10

Medical Report

Section A

Applicant details (details of person providing full-time care)

Surname:

First name:

PPS Number:

Declaration by person receiving full-time care and attention

Section A

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 Protection if this changes.

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

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 Benefit scheme may be reviewed at any time.

Date:
D D M M Y Y Y Y

Signature (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.

Date:
D D M M Y Y Y Y

Signature (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 Benefit 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

Section B

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess if they qualify for care under the Carer's Benefit scheme, please complete the medical report across. 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 fully completing and returning this report. To ensure payment please enter your DSP 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.

If you have any queries, please contact the **Carer's Benefit Section** at LoCall: 1890 92 77 70.

Note:

The carer should already have filled Parts 1 and 8 of the application form. The person(s) being cared for must have completed Section A of this medical report.

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 BENEFIT SECTION.

Section B

1. Patient details

Surname:

First name:

Address:

Date of birth:

D D M M Y Y Y Y

PPS Number:

Mobile telephone Number:

The patient may be contacted by text message in relation to a medical assessment

2. Your patient since:

D D M M Y Y Y Y

3. Diagnosis (use BLOCK CAPITALS):

4. ICD10 Code(s):

5. Date condition started:

D D M M Y Y Y Y

6. How long do you expect this condition to continue?

less than 3 months 3-6 months 6-12 months

12-24 months indefinitely

7. Please give:
Medical history

Surgical/Obstetrical
history

Hospital admissions

Date of discharge:

D	D		M	M		Y	Y	Y	Y

Result of relevant
investigations

8. Please give details if any of the following apply:

Attending a specialist

On medication

Other treatment

9. Pregnant:

Yes No

If **Yes**, give EDD:

D	D		M	M		Y	Y	Y	Y

Please attach any relevant reports/results of investigations.

Additional Information:

ABILITY/DISABILITY PROFILE:

10. Indicate the degree to which your patient’s condition has affected their ability in ALL of the following areas.

	Normal	Mild	Moderate	Severe	Profound
Mental Health/Behaviour →	<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/Rising →	<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/Ladders →	<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"/>

11. A Medical Assessment by one of the Department’s Medical Assessors may be required to determine eligibility.

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

If **No**, give details here:

Doctor’s name:

DSP panel number:

IMC number:

Address:

Doctor’s Signature (not block letters)

Doctor’s official stamp

Date:

D D

M M

2 0

Y Y Y Y

For official use only

(i) Eligible for Carer's Benefit:

(ii) Review:

(iii) DNRA:

(iv) Not eligible for Carer's Benefit:

Give reasons:

Signed _____ Medical Assessor

Date:

D D

M M

2 0 Y Y Y Y

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments and benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at www.gov.ie/dsp/privacystatement or in hard copy.

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