



Application form for Carer's Benefit

How to complete application form for Carer's Benefit.

- Please use this page 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. If a question does not apply to you, please leave the answer area blank.
- You need a Personal Public Service Number (PPS No.) before you apply.

If you do not have a spouse or partner fill in **Parts 1, 2, 3, 4, 5 and 8** as they apply to you. The person(s) you are caring for should sign **Part 10** confirming that they require care. You should then get the doctor to complete the medical report. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

If you have a spouse or partner please fill in **Part 1, 2, 3, 4, 5, 6, 7 and 8** as they apply to you. The person(s) you are caring for should sign **Part 10** confirming that they require care. You should then get the doctor to complete the medical report. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

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.welfare.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 No.:

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														
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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 mother's birth surname:

K	E	L	L	Y															
---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

8. Your date of birth:

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

Contact Details

9. 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										

10. Your telephone number:

0	1	7	0	4	3	0	0	0						
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LANDLINE

0	8	6	1	2	3	4	5	6	7					
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--

MOBILE

11. Your email address:

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

SAMPLE

20. Do you have a second employer?

Yes No

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

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

 D D M M Y Y Y Y

Part 3

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.

22. Please state, your employee's:

Surname:

First name(s):

PPS No.:

23. Is this employment:

Part-time
 Full-time

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

Hours: a week
or
 Hours: a fortnight

(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 **or** a fortnight

To: a week a fortnight

New gross income: € , . a week

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



Part 3 continued

To be completed by your most recent or current employer

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

- Carer's leave
Other (please specify below)

Grid for specifying other leave type

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

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

Period of employment:

Form for PRSI record (a) including date fields (From/To) and PRSI class

or

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

Period of employment:

Form for PRSI record (b) including date fields (From/To) and PRSI class

27. 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):

Grid for number of weeks worked

Signed by or for employer

Signature box

Signature (not block letters)

Date fields (DDMMYYYY)

Employer's registered number field

Position in company or organisation field

Employer's telephone number field

LANDLINE

Employer's telephone number field

MOBILE

Employer's email address field

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 6

Your spouse's or partner's details

29. Their PPS No.:

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30. Title: (insert an 'X' or specify)

Mr.

Mrs.

Ms.

Other

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

31. Their surname:

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

32. Their first name(s):

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

33. Their birth surname:

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

34. Their mother's 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 and do not live together.

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Part 7

Your spouse's or partner's work and claim details

Please complete this section for your spouse or partner.

37. If they are getting a social security payment from this Department or the HSE (for example, Supplementary Welfare Allowance, please state:

Name of country:

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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:

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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.



Has your employer completed Part 3?

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 born or married outside the Republic of Ireland:

- **Your birth certificate**
- **Your marriage certificate**
- **Your child(ren)'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

LoCall: 1890 92 77 70 (from the Republic of Ireland only)

Telephone: Dublin (01) 704 3000

If you are calling from outside the Republic of Ireland please call + 353 43 3340000

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 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 according to the law.

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 No.:

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

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 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 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

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

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

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

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 DSFA 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 No.:

Mobile telephone No.:

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(es)
 (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:



(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

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