



Application form for Respite Care Grant

How to complete application form for Respite Care Grant.

- 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.
- You as the carer should sign the Declaration in Part 1 after you complete the form.
- The person you are caring for must sign the Authorisation in Part 4.
- The doctor of the person receiving care from you must also sign Part 4.

Fill in **Parts 1, 2 and 3** as they apply to you. The person you are caring for should sign **Part 4** confirming that they require care. You should then get the doctor to complete the medical report. When the form is completed, sign declaration in **Part 1**.

Complete this form if you are caring for one care recipient. If you are caring for 2 or more please contact Respite Care Grant Section at (01) 673 2222 and they will forward the correct form RCG 1(a) to you. Alternatively you can download this form from **www.welfare.ie**.

If you need any help to complete this form, please contact your local Social Welfare Office or the Respite Care Grant Section at (01) 673 2222.

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

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.	<input type="checkbox"/>	Mrs.	<input checked="" type="checkbox"/>	Ms.	<input type="checkbox"/>	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 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												
	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

12. What country were you born in?

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13. Are you?

Single Widowed Remarried Divorced
 Married Cohabiting Separated

14. Are you getting Carer's Allowance or Carer's Benefit?

Yes No

If you were getting Carer's Allowance/Benefit on the first Thursday in June. You do not have to complete this form. You will get the Grant automatically for that year. Only one grant is paid for each person receiving full time care and attention.

If 'No', have you ever applied for Carer's Allowance or Carer's Benefit?

Yes No

If 'Yes', what year did you apply?

Y	Y	Y	Y

15. Have you ever applied for Respite Care Grant?

Yes No

If 'Yes', what year did you apply?

Y	Y	Y	Y

16. Are you, or have you been getting Jobseeker's Allowance or Jobseeker's Benefit or are you or have you been signing for credited contributions in the last 18 months?

Yes No

If you are working or attending an educational or training course outside the home for more than 15 hours a week you do not qualify for the Respite Care Grant.

17. Are you, or have you been, employed outside the home in the last 18 months?

Yes No

If 'Yes' please indicate periods of employment and how many hours worked each week:

From:

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To:

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D D M M Y Y Y Y

Hours:

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 a week

From:

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To:

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D D M M Y Y Y Y

Hours:

--	--

 a week

From:

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To:

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D D M M Y Y Y Y

Hours:

--	--

 a week



Part 2

Details of person you are caring for

21. Their PPS No.:

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22. Their surname:

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23. Their first name(s):

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24. Their date of birth:

D	D	M	M	Y	Y	Y	Y		

25. Is anyone else getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance for them?

Yes No

Only one Grant is paid for each person needing full-time care and attention.

26. What is your connection to the person being cared for?

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27. Has anyone applied for the Respite Care Grant for the person named above?

Yes No

28. Has the person being cared for worked outside the home in the last 18 months?

If 'Yes', please state: Yes No

Employer's name:

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Address:

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Type of work:

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Days: a week

Hours: a week



Are you working more than 15 hours per week outside the home?

Yes No

Are you getting Jobseeker's Benefit or Jobseeker's Allowance?

Yes No

Are you signing-on for Jobseeker's Credits?

Yes No

If you answered 'Yes' to any of the above, you are not eligible for the Respite Care Grant. Please do not proceed with this claim.

Are you looking after the person(s) named in this form on a full-time basis?

Yes No

Have you been or will you be providing full-time care and attention for at least 6 months?

Yes No

The grant is only payable where the period of care includes the first Thursday in June.

If you answered 'No' to either of the above, you are not eligible for the Respite Care Grant. Please do not proceed with this claim.

To proceed with this application

- * Check you have given your PPS Number
- * Check you have answered all the questions
- * Check you have given the PPS Number of the person you are caring for
- * Check you have signed the form (Part 1)
- * Have the medical report (Part 4) signed by the person you are caring for and completed by their doctor.

**IMPORTANT! If any information is missing it will delay your application.
Failure to answer any questions could cause a delay in your application**

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

Send this completed application form to:

Respite Care Grant Section

Department of Social and Family Affairs

PO Box 10085

Dublin 2

Telephone: (01) 673 2222



Note to carer

Remember!

You do **not** need to apply for the Respite Care Grant if on the first Thursday in June of the year, you or anyone else, is getting Carer's Allowance, Carer's Benefit, Domiciliary Care Allowance or Prescribed Relative Allowance for caring for this person.

The Respite Care Grant is paid automatically to anyone in these circumstances.

The following medical report is in two parts. **Have Section A completed by the person being cared for.** If the person being cared for cannot complete this form, it should be filled in for them and signed by a witness.

You must then pass the medical report to the doctor of the person being cared for. **The doctor must complete Section B, questions 1-11 inclusive.** As this is quite detailed, the doctor is unlikely to be able to complete the form immediately. You may both agree a suitable time for you to collect it. The doctor may decide to return the form to you in a sealed envelope, for reasons of medical confidentiality.

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



Medical Report for Respite Care Grant



Part 4

Medical Report

Section A

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

Surname:

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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 Respite Care Grant.

I understand that I may need to attend a medical exam from time to time and that my right to care under the Respite Care Grant scheme may be reviewed at any time.

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Date:

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D D

--	--

M M

2	0		
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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.

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Date:

--	--

D D

--	--

M M

2	0		
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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 Respite Care Grant 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 Respite Care Grant 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 **Respite Care Grant Section** at (01) 673 2222

Note:

The carer should already have filled Parts 1 and 2 of the application form. The person 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 RESPITE CARE GRANT 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



Part 4

Medical Report

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:



For Official use Only

(i) Eligible for Respite Care Grant:

(ii) Review:

(iii) DNRA:

(iv) Not eligible for Respite Care Grant:

Give reasons:

Signed _____ Medical Assessor

Date:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2	0	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

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.

