Application form for

Carer's Allowance

Social Welfare Services

CR1

Data Classification R

What is Carer's Allowance?

Carer's Allowance is a means tested payment made to people who are caring full-time for a person who has a disability or illness. The person being cared for must require full-time care and attention.

How do I qualify for Carer's Allowance?

You can qualify for Carer's Allowance if:

- you are 18 years of age or over and are providing full-time care and attention to a person who needs it and who does not normally live in an institution. However, you may continue to be regarded as providing full-time care and attention if you, or the person being cared for, is undergoing medical or other treatment in a hospital or other institution, for a period not longer than 13 weeks; and
- you are not working, self-employed, or on a training or education course for more than 18.5 hours a week.

What do I need to complete this application form?

You will need your Personal Public Service (PPS) Number along with information on where you live, your partner, your children, your relationship status and where you want your payment to issue.

How to complete this application form?

There are examples on the back of this page that can be used as a guide to fill in this form. Please:

- write with a **black** ballpoint pen, use **capital letters** and place an **X** in the relevant boxes;
- fill in **Parts 1** to **7** as they apply to you and your household;
- sign the declaration in **Part 8**;
- fill in the checklist in **Part 9**;
- fill in **Section 1** of **Part 10**;
- complete **Section 2** of **Part 10,** and have it signed by the person you are caring for; **and**
- have the care recipient's doctor complete **Section 3** of **Part 10** and have them return it to you.

How do I apply?

Send this completed form to:

Carer's Allowance Section
Social Welfare Services
Government Buildings
Ballinalee Road
Longford
N39 E4E0

How can I get help and further information?

If you need any help to complete this form, please contact the Carer's Allowance Section on **(043) 334 0000** or **0818 927 770**, your local Intreo Centre or Social Welfare Office or any Citizens Information Centre. You can find the name and address of your local Intreo Centre or Social Welfare Office by visiting **www.gov.ie/intreocentres**

For more information, visit **www.gov.ie/CA**

How to fill in this form

To help us process your application, write letters and numbers clearly and use one box for each. Please see examples below.

Part 1 — Your details (Carer's details)

1. 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 names: M A U R E E N

5. Birth surname: M C D E R M O T T

6. Date of birth: 2 8 (D D) 0 2 (M M) 1 9 7 0 (Y Y Y Y)

7. Address: 1 NEW STREET
OLD TOWN
DONEGAL TOWN
County DONEGAL Eircode C15A96V

8. Telephone number: 0 8 8 1 2 3 4 5 6 7

9. Email address: MMURPHY@WELFARE.IE

10. Are you?

- ☐ Single
- ☒ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabiting
- ☐ In a Civil Partnership
- ☐ A surviving Civil Partner
- ☐ A former Civil Partner (you were in a Civil Partnership that has since been dissolved)

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Part 1 Your details (Carer's details)

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2. Title, insert an **X** or specify: Mr ☐ Mrs ☐ Ms ☐ Other

3. Surname:

4. First names:

5. Birth surname:

6. Date of birth: D D M M Y Y Y Y

7. Address:

County Eircode

8. Telephone number:

9. Email address:

10. Are you?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabiting
- ☐ In a Civil Partnership
- ☐ A surviving Civil Partner
- ☐ A former Civil Partner

(you were in a Civil Partnership that has since been dissolved)

11. If you are married, in a civil partnership or cohabiting, from what date? D D M M Y Y Y Y

Part 2 Your partner's details

12. PPS Number:

13. Title, insert an **X** or specify: Mr ☐ Mrs ☐ Ms ☐ Other

14. Surname:

15. First names:

16. Date of birth:

D D M M Y Y Y Y

17. Address:

County Eircode

Note: Only complete Question 17 if you are married or in a civil partnership and do not live together.

Part 3 You and your partner's work and claim details

Carer's Allowance is a means tested payment. You are required by law to declare **all** your financial resources. For example, money in cash or in a financial institution, savings, shares, bonds, funds, foreign pensions or properties (other than your own home).

Please include written evidence such as statements and payslips with your application. You must also declare the means of your partner. Failure to do so could result in your claim being disallowed or a delay in the processing of your application.

18. Are you or your partner employed?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No

If **yes**, please attach three recent payslips.

19. Are you or your partner currently self-employed or have either of you been self-employed in the past?

		You		Partner	
		☐ Yes	☐ No	☐ Yes	☐ No
		If **yes**, please state:			
Business name:					
Type of employment:					
Please supply the most recent set of accounts.					
Dates of self-employment	From:				
	To:				
		D D / M M / Y Y Y Y		D D / M M / Y Y Y Y	

Note: If self-employment has stopped, please provide documents to show how and when it ended.

20. Are you or your partner taking part in any courses or any type of employment schemes?

		You		Partner	
		☐ Yes	☐ No	☐ Yes	☐ No
		If **yes**, please state:			
The name of the course or scheme:					
Course or scheme dates:	From:				
	To:				
		D D / M M / Y Y Y Y		D D / M M / Y Y Y Y	
What is the payment for doing this course or scheme per week?		€		€	

Please provide a letter from the course or scheme providers detailing payments received.

21. Are you or your partner receiving maintenance that is not paid in respect of a child?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
If maintenance is received, please state the amount:				
Weekly amount:	€		€	
If an amount of mortgage or rent is paid, please state the amount paid per week:				
Weekly amount:	€		€	

Please attach a copy of the maintenance agreement as well as a statement from the mortgage provider or a rent receipt from the agency or landlord.

22. Are you or your partner in receipt of of a Social Protection payment, pension or an allowance from Ireland or any other country?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If **yes**, please state:			
Name of country:				
Claim or reference number:				
Weekly amount:	€		€	

If **yes**, please attach the most recent payslips, statements or letters from the people who pay confirming the above amounts. Also, please provide 3 recent months statements from the account to which the payments are made.

23. Do you, or your partner hold, or jointly hold, any savings or accounts in a post office, bank, building society, credit union or any other financial institution in Ireland or another country?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No

If **yes**, please provide 3 recent months statements for each account held.

24. Do you or your partner own stocks, shares including shares in a creamery or Co-op, annuities, bonds, insurance policies or investments in Ireland or another country?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No

If **yes**, please attach up to date statements showing details and current market values.

25. Do you or your partner own, share in the ownership, work or rent a farm or land?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If **yes**, please state:			
Net yearly income from farm or land:	€		€	

Note: Net yearly income is money you have made from the farm or land after deducting operating expenses

Please provide a most recent set of farm accounts. If the land is leased, please provide a copy of the lease agreement

26. Do you or your partner have any other income in Ireland or from another country?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No
If **yes**, please give details in the box below:			

27. Do you or your partner own or share in the ownership of property apart from your home?

Note: Property is an apartment, business property, house or land other than that mentioned at question 25.

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If **yes**, please state:			
Address of property:				
Country:				
Current market value:				

For properties listed above, please provide:

- A valuation from an authorised auctioneer or valuer for the properties.
- Recent statements from the lending institutions if mortgaged.
- A copy of the rent or lease agreements if rental income is received.

A separate sheet of paper can be used for details of any additional properties.

28. Did you or your partner sell or transfer property, a business or your home in the last three years?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No
If **yes**, please outline the circumstances in the space below and attach documents from your solicitors regarding the financial transactions:			

Part 4 Details of the person you are caring for

29. PPS number:

30. Title, insert an **X** or specify: Mr ☐ Mrs ☐ Ms ☐ Other

31. Surname:

32. First names:

33. Birth surname:

34. Date of birth:

D D M M Y Y Y Y

35. Address:

County Eircode

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

37. If you do not live with the cared for person, please state:

What systems of communication exists between the households?

☐ Community Alert Alarm ☐ Landline phone

☐ Mobile phone ☐ Other

If **other**, please specify:

What is the distance between your home and the home of the person you are caring for?

☐☐☐ miles **or** ☐☐☐ kilometres

38. How many days a week do you provide care? ☐ days

39. How many hours a day do you provide care? Insert the hours for each day:

☐☐ Monday ☐☐ Tuesday ☐☐ Wednesday

☐☐ Thursday ☐☐ Friday ☐☐ Saturday

☐☐ Sunday

Details of the person you are caring for

40. If you share the provision of care with someone else, when do you mostly provide care?

☐ Morning ☐ Afternoon ☐ Evening
☐ Night time ☐ All day

41. When did you start caring for this person?

D D M M Y Y Y Y

If you have taken over the provision of care please state:

a) Previous carer's name:

Surname:

First names:

and

b) Date the person cared for left hospital or nursing home:

D D M M Y Y Y Y

Please provide a letter from the hospital or nursing home confirming the date the care recipient was discharged.

42. Is the cared for person attending a day care or rehabilitative centre? ☐ Yes ☐ No

Does the cared for person stay overnight at a care facility or centre? ☐ Yes ☐ No

If **yes** to either of the above, please state:

Name of centre:

Address of centre:

County Eircode

Number of: ☐ days they attend a week ☐ nights they attend a week

Note: A person can be regarded as receiving full-time care and attention while attending a day care centre during the daytime. If the person stays overnight, you must state this clearly.

Please attach a letter of confirmation from the care centre.

43. Does anyone else live with the person you are caring for? ☐ Yes ☐ No

If **yes**, give details below:

44. Have you moved from your home to live with the person you are caring for?

If **yes**, give details below if your home is rented, occupied by other people or otherwise used:

Important: Where you can show to our satisfaction that adequate care has been or will be provided in your absence for the care recipient, you can work, be self-employed or engage in training or an education course up to a maximum of 18.5 hours per week.

If you are working or studying in excess of 18.5 hours a week, you do not have an entitlement to Carer's Allowance. Prior to applying for Carer's Allowance you must reduce your hours to 18.5 or less.

45. When in receipt of Carer's Allowance do you intend to:

Work?	☐ Yes	☐ No	Number of hours a week.	☐☐
Be self-employed?	☐ Yes	☐ No	Number of hours a week.	☐☐
Be engaged on a training or education course?	☐ Yes	☐ No	Number of hours a week.	☐☐

If **yes**, please provide a letter from your course provider confirming how many hours a week in total you are expected to do. This includes hours attending lectures, practicals, seminars, study, coursework or assignments.

46. If you were working and/or studying in excess of 18.5 hours a week, from what date did you reduce the combined hours of these activities to 18.5 hours or less?

☐☐ ☐☐ ☐☐☐☐
D D M M Y Y Y Y

47. What arrangements will be made for the care of the person you care for, while you are working training or on an education course?

Part 5 Nationality and details of where you have lived

48. What country were you born in?

49. What is your nationality?

50. Have you lived outside of Ireland for any period longer than three months within the last five years? ☐ Yes ☐ No

If **yes**, please give details of where you lived and why:

Country 1

Country:

From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Why did you live there?

Country 2

Country:

From: D D M M Y Y Y Y To: D D M M Y Y Y Y

Why did you live there?

Part 6 Details of your children

Note: An increase for a qualified child may be payable for each child under 18 years of age who is normally resident with and is being maintained by you. This increase may also be payable for a child over 18 years of age, who is in full-time education at a recognised school or college up to the end of the academic year in which they reach 22 years of age.

51. Do you wish to apply for your children? ☐ Yes ☐ No

If **yes**, please provide details of your children which you wish to apply for below.

Note: you must attach written confirmation from the school or college for children aged 18 - 22 years of age.

Child 1

Surname:

First names:

PPS number:

Do they live with you? ☐ Yes ☐ No

Child 2

Surname:

First names:

PPS number:

Do they live with you? ☐ Yes ☐ No

Child 3

Surname:

First names:

PPS number:

Do they live with you? ☐ Yes ☐ No

Note: A separate sheet of paper can be used for details of other children.

Part 7 Your payment details

You can get your payment at a post office of your choice or direct to your current, deposit or savings account in a financial institution. An account must be in your name or jointly held by you.

Where would you would like to get your Carer's Allowance payment? Complete one option below:

Financial Institution

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Names of account holders:

Name 1:

Name 2, if any:

Post Office

Name:

Address:

County

Eircode

Note: You will need a Public Services Card (PSC) to collect your payment at a Post Office.

Part 8 Declaration

I declare that the information given by me on all parts of this form is truthful and complete. I understand that if any of the information I provide is untrue or misleading or if I fail to disclose any relevant information, I will be required to repay any payment I receive from the department and that I may be prosecuted. I undertake to immediately advise the department of any change in my circumstances which may affect my continued entitlement.

If you cannot sign your name, make a mark such as an **X** and have it witnessed by a non-relative.

Signature or mark, **not** capital letters.

Date: D D M M 2 0 Y Y Y Y

Signature of witness, **not** capital letters.

Date: D D M M 2 0 Y Y Y Y

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

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.

Part 9 Checklist

Failure to complete this claim form in full, or to provide the required additional information, may result in delays in processing your claim.

Please use the checklist below as a guide to ensure that you have supplied all the required information with your claim.

This claim form must be signed in **Part 8** and the Medical Report in **Part 10** must also be complete.

Additional information	Relevant Question	Provided, Yes or No
Three recent payslips for you and your spouse, civil partner or cohabitant.	18	
Most recent set of business or farm accounts.	19 and 25	
Letter from course or scheme provider stating income each week.	20	
Copy of maintenance agreement.	21	
Letter or payslip providing details of any Social Protection payment, pension, allowance or income you are in receipt of.	22	
Three months statements from all financial institutions where you or your partner have accounts.	23	
Most recent statements of stocks or shares you or your partner may own.	24	
A copy of farm lease agreement.	25	
Details including current valuation, mortgage, rental income for any properties owed by you or your partner, apart from your family home.	27	
Documents from your solicitor detailing the sale, transfer of property, business or home in the last three years for you or your partner.	28	
A letter from hospital confirming date the care recipient was discharged.	41	
If the cared for person stays overnight in a Care Facility or Centre, a letter of confirmation from the Care Facility or Centre?	42	
Letter from education provider for children between 18 and 22 years of age.	51	

Certificates	
Birth and marriage certificates are only required if registered outside of the State	
Your birth certificate.	
Spouse, civil partner or cohabitant birth certificate	
Marriage, civil partnership or civil union registration certificate	
Children’s birth certificates. They are not needed if you are already claiming Child Benefit for the children.	

Information for Carer

If you are applying for Carers Allowance for a child under 16 years of age, Domiciliary Care Allowance must be in payment for that child.

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

The following Medical Report, **Part 10**, is in three sections:

Section 1 - should be completed by you. It allows you to tell us about the care requirements of the person you are caring for.

Section 2 - should be completed by you and signed by the person you are caring for, that is the care recipient.

We understand that there are times when the care recipient cannot sign Section 2, for example in some cases of intellectual disability, mental illness or physical incapacity. In these cases the form can remain unsigned as long as the evidence from the doctor supports that they are unable to or detrimental to them to sign it.

Section 3 - give the entire Medical Report to the doctor, who must be a medical practitioner registered with the Irish Medical Council, of the person being cared for. The doctor will complete and sign Section 3 and may return the form to you in a sealed envelope to keep their patient's medical details confidential.

Note: Please make sure you return the Medical Report along with your application.

Part 10 Medical report

Section 1

Carer's details:

PPS number:

Surname:

First names:

Care recipient's details:

Surname:

First names:

In the rest of Section 1, please provide details about the care you are providing to the person being cared for.

If you want to provide further information on the care you are providing, add sheets of paper with your PPS number on them. Please put the appropriate heading before each piece of additional information, for example, neurological conditions, mental health, personal care, mobility and so on.

Neurological conditions

Does the person suffer from loss of or impaired level of consciousness? ☐ Yes ☐ No

Does the person have an intellectual disability? ☐ Yes ☐ No

Does the person have memory impairment or dementia? ☐ Yes ☐ No

If **yes** to any of the above, describe what care you provide?

Mental health

Does the person have a mental health condition? ☐ Yes ☐ No

If **yes**, describe what care you provide?

Personal care

Does the person have difficulty with communication?	☐ Yes	☐ No
Does the person have difficulty hearing?	☐ Yes	☐ No
Does the person have difficulty with vision?	☐ Yes	☐ No
Does the person have difficulty with eating or drinking?	☐ Yes	☐ No
Does the person have difficulty bathing or showering?	☐ Yes	☐ No
Does this person have difficulty with dressing?	☐ Yes	☐ No
Does the person have continence problems or require assistance with using the toilet?	☐ Yes	☐ No
Does the person have difficulty sleeping?	☐ Yes	☐ No

If **yes** to any of the above, please describe what care you provide:

Mobility

Does the person have difficulty with walking or mobility?	☐ Yes	☐ No

If **yes,** please describe what care you provide:

Additional needs

Please detail any additional needs that the person has and which you provide care for, including how often and for how long. Examples might include:

- Use of specialist equipment.
- Dialysis.
- Dressing of chronic wounds.
- Preparation of or administration of medication.

Describe what care you provide:

Is there any other relevant information you wish to provide in support of your application or raise any area of concern not addressed in previous pages?

Section 2

Carer's details:

PPS number:

Surname:

First names:

If there has been a carer in receipt of Carers Allowance for this care recipient previously, please provide their:

Surname:

First names:

Care recipient's declaration and authorisation

I confirm that I need **full-time care** and **attention** and the carer named above is providing full-time care and attention to me.

I allow my doctors to provide the Department of Social Protection with the medical information that it needs to process this application. Please note, one of the department's medical assessors will review this information and treat it with the strictest confidence. Although a confidential report, both medical and non-medical staff will need to see this report in order to process your claim.

I understand that I may need to attend medical examinations on occasion, and my right to care under the scheme may be reviewed at any time.

I will inform the Department of Social Protection if this changes.

Date: D D M M 2 0 Y Y Y Y

Signature of the person receiving care, **not** capital 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 of witness, **not** capital letters.

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

Information for Doctor

Section 3 must be completed and signed by a doctor who is a medical practitioner registered with the Irish Medical Council.

Dear Doctor,

To enable us to accurately assess the level of care and attention your patient requires, please complete Section 3, medical report. The medical information provided will be reviewed by a doctor (Medical Assessor), who will treat it in strictest confidence. Although a confidential report, both medical and non-medical staff will need to deal with this report in order to process the claim.

You will be paid 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, without potential inspection by a third party, you may wish to send the medical report to the department's Chief Medical Advisor. If you have any questions on this matter, please contact the Carer's Allowance section on 043 334 0000 or 0818 927 770 or +353 43 334 0000 if calling from outside of Ireland.

Please return the completed medical report to the carer in a sealed envelope if necessary, to keep the patient's medical details confidential.

Section 3

Patient details: Please use capital letters

Surname:

First name:

Address:

County Eircode

Date of birth: D D M M Y Y Y Y

PPS number:

Your patient since: ☐ Less than 1 year ☐ 1 to 5 years ☐ More than 5 years

Main diagnosis or diagnoses:

Diagnosis (relevant to application)	Date (MM/YY) (if relevant)	ICD10 code
1.		
2.		
3.		
4.		
5.		
6.		

Current medications:

Medication (relevant to application)	Dose	Medication (if relevant)	Dose (if relevant)
1.		**5.**	
2.		**6.**	
3.		**7.**	
4.		**8.**	

Is your patient terminally ill? ☐ Yes ☐ No

Please give details of the following:

Relevant hospital admissions and attending specialists (recent or relevant dates and approximate duration):

Please attach any relevant reports, staging and results of investigations, if available.

Other information, if relevant:

Please describe your patient's care needs under the following headings:

Cognition

	☐ Normal	☐ Impaired
Dementia:	☐ Yes	☐ No
General learning disability:	☐ Yes	☐ No

If **yes** to either, state the level of care provided:

Results of MMSE, FSIQ, MOCA or equivalent, if available:

Mental health

☐ Normal ☐ Impaired

Please state the level of care and support provided and any specific concerns:

Seizures

☐ Stable ☐ Unstable

If **unstable**, state frequency:

Epilepsy: ☐ Yes ☐ No

If **yes**, please state what type:

Please indicate the degree to which your patient's faculties have been affected and the level of care provided in the following, if known:

	Normal	Glasses or Hearing Aids	Impaired	If impaired, please describe known care needs:
Vision	☐	☐	☐	
Hearing	☐	☐	☐	
Speech	☐	☐	☐	

	Independent	Dependent	Don't know	If dependent, please describe known care needs:
Continence/Toileting	☐	☐	☐	
Bathing/Showering	☐	☐	☐	
Feeding	☐	☐	☐	
Dressing	☐	☐	☐	

Mobility

☐ Independent or age appropriate ☐ Dependent

Please describe care required. For example, needs assistance, walking aids, immobility or wheelchair dependency:

Specific conditions

How long do you expect these care needs to continue?

☐ Less than 12 months ☐ 12-24 months

☐ Indefinitely ☐ Unknown

Current clinical findings, care needs or concerns:

Doctor's declaration

Doctor's name:

DSP panel number:

IMC number:

Address:

County

Eircode

Doctor's signature, **not** capital letters.

Doctor's official stamp

Date: D D M M Y Y Y Y (2 0 _ _)

Data Protection Statement

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