SOCIAL WELFARE SERVICES OFFICE
CR 1

Application form for Carer's Allowance

- Please read information booklet **SW 41,** especially section 15, before completing this application form.
- Please use BLOCK LETTERS and place a tick (3) in the appropriate boxes.
- Please answer **all** questions. Incomplete forms may have to be returned to you. This will cause a delay in processing your application.
- Please make sure that the person(s) receiving care from you signs Part 8 of this form, and that the doctor(s) completes Part 11.
- Please complete this form for you and your spouse or partner, if relevant.
- You as the carer must sign Part 9.

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. 8940.

Part 1 Your own details

1. Please state: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____ Please specify

2. What is your name?
Last name
First name(s)

3. What is your birth surname (your surname before you were married), if different?

4. Where do you live?
Address

5. What is your telephone number?
Code number

6. What is your date of birth? (Attach your Birth Certificate).
☐☐ Day ☐☐ Month ☐☐☐☐ Year

7. What country were you born in?

8. What is your Personal Public Service Number (PPS No.)**?** (same as RSI or tax number)

Figures	Letter(s)

9. Are you.....?
'Cohabiting' means you live with a man or woman as husband or wife and you are not married to them.

☐ Married ☐ Single ☐ Separated
☐ Widowed ☐ Divorced ☐ Cohabiting

Please attach relevant documents relating to your marriage, separation or divorce, if applicable.

10. When did you get married? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

Your own details

11. Have you ever claimed a Carer's Allowance before? ☐ Yes ☐ No

Your address when you claimed:

12. Are you getting any payment from this Department or the Health Service Executive (for example, Supplementary Welfare Allowance)? ☐ Yes ☐ No

Since January 2005 the Health Boards were replaced by the Health Service Executive (HSE).

If 'Yes', please state:

Name of payment:

Weekly amount: €

Your claim or reference number:

If you are getting Unemployment Benefit or Assistance, state the name of local Social Welfare Office:

Have you had a social welfare means test in the last 12 months? ☐ Yes ☐ No

14. Are you getting a social security payment from another country? ☐ Yes ☐ No

If 'Yes', please state:

Amount of payment you get each week: €

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

Name of country that pays you:

Your own details

15. Are you getting an occupational or private pension? ☐ Yes ☐ No

If 'Yes', please state:

Who pays this pension:

Amount you get each week: €

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

16. Are you employed or self-employed (including farming) at present? ☐ Yes ☐ No

If 'Yes', please state:

Type of work you do:

Where you work:

How many hours do you work each week?

Name and address of employer:

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

Amount of gross weekly earnings: €

17. (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 7? ☐ Yes ☐ No

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

(b) You can work for up to 10 hours per week outside the home. Do you intend to....?

(i) remain at work for up to 10 hours per week ☐ * Yes ☐ No

or

(ii) return to work for up to 10 hours per week ☐ * Yes ☐ No

* Please get a statement from your employer and attach it to this application. The statement should show the number of hours to be worked and the wages earned. If you are reducing your working hours to 10, the statement should include the date on which this takes place. Where you are self-employed, please attach a note showing type of work, proposed number of hours and income.

(c) Who will look after the person being cared for in your absence?

Part 2 Payment details

You can get Carer's Allowance paid (every week in arrears) direct to your bank or building society account or (every week in advance) at your post office.

This account must be a current or deposit savings account (not a mortgage account)

Direct payment has a number of advantages:
- **your payment is lodged directly to your account on the day of payment,**
- **your payment is available at a time and place that suits you, and**
- **you are less likely to deal with delays and queuing.**

Dealings between you and your financial institution remain confidential. The Department does not have access to your bank or building society account.

18. Please state if you want to get your payment

☐ into a bank account ☐ into a building society account

☐ a book of payable orders at a post office

19. If you want to get your payment by direct payment, please give details of your bank or building society

Name of bank or building society:

Address:

Name on the account:

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

Type of account:

Account number (8 digits).

Bank sort code (you can get this from your branch).

If with First Active PLC you must use a deposit account.

Payment details

20. If you would like to be paid by a book of payable orders that you can cash at a post office, please state:

Name of post office:

Address:

If you are unable to collect or cash your payment at the post office and you want someone else (known as an agent) to do so for you, please give:

Your agent's name:

Your agent's address:

Why do you need an agent to collect your payment?

Ask the person you have appointed as an agent to sign below:

I agree to act as an agent for _____ **and agree to collect Carer's Allowance at the post office named above for them.**

Agent's signature:

Date:

Part 3 Habitual Residence Condition

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

21. In what country were you born?

22. What is your nationality?

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.

23. Have you lived in the Common Travel Area all of your life? ☐ Yes ☐ No

If 'Yes', please complete questions 27 and 28.

If 'No', please complete questions 24-28.

Country	From	To	Why you lived there

24. When did you come to Ireland? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

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

25. 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		

Part 3 Habitual Residence Condition

26. Have you ever made an application for Refugee Status? ☐ Yes ☐ No

If 'Yes', please answer both questions 26(a) and 26(b) and provide copies of all relevant documentation from the Department of Justice, Equality and Law Reform.

(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 on other grounds? ☐ Yes ☐ No

27. Please state where you lived in the Common Travel Area. ☐ Ireland ☐ Great Britain ☐ Isle of Man ☐ Channel Islands

28. Have you lived at the same address for the last 2 years? ☐ Yes ☐ No

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

Last address	Previous address
From	From
To	To

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HRC satisfied ☐ **HRC not satisfied** ☐ **HRC 1 issued** ☐

Part 4 Details of your means

29. 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 balance for the last 12 months.

b) Have you any savings in cash?

☐ Yes ☐ No

If 'Yes', please state:

Amount: €

30. Have you any investments or shares?

☐ Yes ☐ No

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

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

☐ Yes ☐ No

If 'Yes', please state:

Type of property:

Address:

Current market value: €

32. 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:

33. 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.

Details of your means

34. (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 or aunt? ☐ Yes ☐ No

If 'Yes' to either a) or b) please state:

Size of the farm or land: _____ acres

Your net yearly income from the farm or land: € _____

Please attach any available statements or documents to confirm this figure

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: ☐☐ Day ☐☐ Month ☐☐☐☐ Year

35. If you are separated or divorced, are you getting maintenance? ☐ Yes ☐ No

If 'Yes', does a formal Maintenance Order or Separation Agreement exist? ☐ Yes ☐ No

Maintenance for you: € _____ week/month*

Maintenance for children: € _____ week/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 5 Your spouse's or partner's details

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

Last name

First name(s)

37. What is their birth surname (their surname before they married), if different?

38. What is their address?

39. What is their telephone number?

Code Local number

40. What is their date of birth?

Day Month Year

41. In what country were they born?

42. What is their nationality?

43. What is their Personal Public Service Number (PPS No.)? (same as RSI or tax number)

FIGURES LETTER(S)

44. 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:

Weekly amount: €

Their claim or reference number:

If claiming Unemployment Benefit or Assistance, state name of local Social Welfare Office:

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

Yes No

If 'Yes', please state:

Name of payment:

Person's name:

Weekly amount: €

Their claim or reference number:

Your spouse's or partner's details

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

☐ Yes ☐ No

If 'Yes', please attach amount of payment they get each week.
Please attach a recent slip or letter from the social security agency to confirm this amount.

If 'Yes', please state:

Amount of payment they get a week €

Name of country that pays them:

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

☐ Yes ☐ No

If 'Yes', please state:

Who pays this pension:

Amount they get each week: €

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

48. Is your spouse or partner employed or self-employed (including farming) at present?

☐ Yes ☐ No

If 'Yes', please state:

Type of work they do:

Where they work:

Name and address of employer:

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

Amount of weekly earnings: €

49. 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 balance for the last 12 months.

Has your spouse or partner any savings in cash?

☐ Yes ☐ No

If 'Yes', please state amount: €

50. 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.

Your spouse's or partner's details

51. 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: €

52. 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.

53. (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 or aunt? ☐ Yes ☐ No

If 'Yes' to either a) or b) please state:

Size of the farm or land acres

Their net yearly income from the farm or land €

Please attach any available statements or documents to confirm this figure.

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

Part 6 Child dependant details

54. 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:

Include any child you are maintaining, 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 child dependant need not be your own child. If you maintain a child and get Child Benefit or Foster Allowance for them, you may claim for this child as a dependant.

55 Does each child live with you? ☐ Yes ☐ No

Dependent 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:
Address:

Amount of maintenance paid by you, if any: € week/month*

*delete as appropriate

Part 7 Details of person(s) you are caring for

	Person 1	Person 2 (if applicable)
56. What is their full name?	Last name First name(s)	Last name First name(s)
57. What is their birth surname (the surname before they married), if different?		
58. Where do they live?	Address	Address
59. What is their date of birth?	Day Month Year	Day Month Year
60. What is their Personal Public Service Number (PPS No.)? (same as RSI or tax number)	Figures Letter(s)	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. What country pays them, if any?		
64. Are you getting any payment from the Health Service Executive for caring for this person(s)? If you are getting Domiciliary Care Allowance, you must give evidence of payment.	☐ Yes ☐ No	☐ Yes ☐ No

Details of person(s) you are caring for

	Person 1	Person 2 (if applicable)
65. Is the person(s) named at Question 56 attending a day care or rehabilitative centre by day?	☐ Yes ☐ No	☐ Yes ☐ No
If 'Yes', please state:		
Name of centre:		
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.	Address	Address
Telephone number of centre:	Code Local number	Code Local number
Number of days they attend:	days a week	days a week
Number of hours a day:	hours a day	hours a day
66. Does each person you are caring for live with you?	☐ Yes ☐ No	☐ Yes ☐ No
If 'No', please state:		
Distance between households:		
If there is a direct phone link?	☐ Yes ☐ No	☐ Yes ☐ No
Is there any other type of direct link (if there is no phone)?	☐ Yes ☐ No	☐ 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.

Details of person(s) you are caring for

Complete questions 67-73 if you are caring for more than 2 people. Please contact Carer's Allowance Section to request additional medical report forms for them.

67. Are you caring for any person other than the person(s) named in Part 7, Q.56? ☐ Yes ☐ No

If 'Yes', please state:

	Person 3 (if applicable)	Person 4 (if applicable)
68. What is their full name?	Last name First name(s)	Last name First name(s)
69. Where do they live?	Address	Address
70. What is their date of birth?	Day Month Year	Day Month Year
71. What is their Personal Public Service Number (PPS No.)? (same as RSI or tax number)	Figures Letter(s)	Figures Letter(s)
72. Is the person(s) named at Question 68 attending a day care or rehabilitative centre by day?	☐ Yes ☐ No	☐ Yes ☐ No
If 'Yes', please state:		
Name of centre:		
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.	Address	Address
Telephone number of centre:	Code Local number	Code Local number
Number of days they attend:	days a week	days a week
Number of hours a day:	hours a day	hours a day

Details of person(s) you are caring for

	Person 3 (if applicable)		Person 4 (if applicable)	
73. Does each person you are caring for live with you?	☐ Yes	☐ No	☐ Yes	☐ No
If 'No', please state:				
Distance between households:				
If there is a direct phone link?	☐ Yes	☐ No	☐ Yes	☐ No
Is there any other type of direct link (if there is no phone)?	☐ Yes	☐ No	☐ 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.

Part 8 Declaration by person(s) receiving full-time care and attention

This must be signed by the person who is receiving care

Person 1

I am in need of **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.

Signed

(**not** block letters)

Date

If you cannot sign, make your mark and have it witnessed.

If the person being cared for is under age 16 or cannot manage their own affairs, this section should be witnessed by an independent witness. The witness cannot be the carer or a member of the carer's household.

Signature of witness

(**not** block letters)

Address of witness

Person 2 (if applicable)

I am in need of **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.

Signed

(**not** block letters)

Date

If you cannot sign, make your mark and have it witnessed.

If the person being cared for is under age 16 or cannot manage their own affairs, this section should be witnessed by an independent witness. The witness cannot be the carer or a member of the carer's household.

Signature of witness

(**not** block letters)

Address of witness

Person 3 (if applicable)

I am in need of **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.

Signed

(**not** block letters)

Date

If you cannot sign, make your mark and have it witnessed.

If the person being cared for is under age 16 or cannot manage their own affairs, this section should be witnessed by an independent witness. The witness cannot be the carer or a member of the carer's household.

Signature of witness

(**not** block letters)

Address of witness

Person 4 (if applicable)

I am in need of **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.

Signed

(**not** block letters)

Date

If you cannot sign, make your mark and have it witnessed.

If the person being cared for is under age 16 or cannot manage their own affairs, this section should be witnessed by an independent witness. The witness cannot be the carer or a member of the carer's household.

Signature of witness

(**not** block letters)

Address of witness

Part 9 Declaration by you - the carer

Important: Please complete this section fully. If you don't, your application cannot be processed.

I apply for Carer's Allowance. All the information I have given is true.

I understand that a Social Welfare Inspector can investigate and review my entitlement to Carer's Allowance at any time. I have given full details of my means and I will tell the Department of Social and Family Affairs within 7 days of any change in my means.

To the best of my belief, the person(s) named in Part 8 requires full-time care and attention. I am the person providing full-time care and attention and I will tell the Department immediately if there is any change in circumstances affecting my entitlement.

Signed	Date

(**not** block letters)

If you (person providing care) cannot sign, make your mark and have it witnessed. The witness cannot be the person being cared for or a member of the carer's household.

Signature of witness	Date

(**not** block letters)

Address of witness

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

Part 10 Checklist of certificates and documents

Your application will be delayed if you do not send in **all** the necessary certificates and documents. If you are not sending in certain certificates or documents, please enclose a note stating that they will follow later.

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 with your application		
• **Your Birth Certificate (long version)**	☐ Yes	☐ No
• **Your Marriage Certificate (if relevant)**	☐ 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 or a statement from accountant, if self-employed**	☐ Yes	☐ No
• **Statement(s) from financial institutions (for example bank, post office)**	☐ Yes	☐ No
• **Payslip or letter, if getting an occupational or private pension**	☐ Yes	☐ No
4. Have you signed the claim form where requested?	☐ Yes	☐ No

We will return all certificates

If you have a problem getting any of the certificates or documents, please contact Carer's Allowance Section.

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. 8940
Dublin (01) 704 3000

If you need help to fill in this form, please phone us in the Carer's Allowance Section at the telephone numbers above or call to your local Social Welfare Office.

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 which you give as confidential. We will only disclose it to other bodies in accordance with law. We are responsible for your information under the Data Protection Act and Freedom of Information Act.

Note to carer

Important

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

The following medical forms are in two parts. **Have Part A completed by the person(s) being cared for**. If the person being cared for cannot complete this form, you should fill it in for them and have it signed by a witness.

You must then pass the entire medical form to the doctor of the person being cared for. **The doctor must complete Part B, questions 1 -7 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 (Person 1)

Part A (to be completed by the person being cared for)

Authorisation

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 entitlement to care under the Carer's Allowance scheme may be reviewed at any time.

Part A - Person 1

Your signature or mark	Date

(**not** block letters)

If you cannot sign, have somebody witness your authorisation and sign below on your behalf. 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.

Medical report (Person 1)

Part 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 fully 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. 8940**

Note:

The carer should already have filled Part 1 Question 1 and Parts 7 and 9 of the application form. The person(s) being cared for must have completed Part A of this medical report section.

Part B - Person 1

1. Patient's full name and address:

Name

Address

Date of birth: Day Month Year

Your patient since: Day Month Year

2. Diagnosis (use BLOCK LETTERS)

3. Date incapacity started: Day Month Year

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

- ☐ less than 12 months
- ☐ 12-24 months
- ☐ 24-48 months
- ☐ 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
- Attending a specialist ☐ Y/N
- On medication ☐ Y/N
- Other treatment ☐ Y/N
- Pregnant ☐ Y/N
- If 'Y', give EDD: Day Month Year

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

Part 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	☐	☐	☐	☐	☐
Learning	☐	☐	☐	☐	☐
Consciousness	☐	☐	☐	☐	☐
Balance	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Lifting or carrying	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Bending, kneeling or squatting	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

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:

Your signature

(**not** block letters)

Date

DSFA Panel Number

Address

Doctor's Official Stamp

Medical report (Person 2)

Part A (to be completed by the person being cared for)

Authorisation

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 entitlement to care under the Carer's Allowance scheme may be reviewed at any time.

Part A - Person 2

Your signature or mark	Date

(**not** block letters)

If you cannot sign, have somebody witness your authorisation and sign below on your behalf. 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 issue to 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.

Medical report (Person 2)

Part 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 fully 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. 8940**

Note:

The carer should already have filled Part 1 Question 1 and Parts 7 and 9 of the application form. The person(s) being cared for must have completed Part A of this medical report section.

Part B - Person 2

1. Patient's full name and address

Name

Address

Date of birth: Day Month Year

Your patient since: Day Month Year

2. Diagnosis (use BLOCK LETTERS)

3. Date incapacity started Day Month Year

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

☐ less than 12 months ☐ 12-24 months

☐ 24-48 months ☐ 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
- Attending a specialist ☐ Y/N
- On medication ☐ Y/N
- Other treatment ☐ Y/N
- Pregnant ☐ Y/N
- If 'Y', give EDD: Day Month Year

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

Part 2 - 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 →	☐	☐	☐	☐	☐
Learning →	☐	☐	☐	☐	☐
Consciousness →	☐	☐	☐	☐	☐
Balance →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Lifting or carrying →	☐	☐	☐	☐	☐
Manual dexterity →	☐	☐	☐	☐	☐
Bending, kneeling or squatting →	☐	☐	☐	☐	☐
Sitting →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing stairs →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

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:

Your signature

(**not** block letters)

Date

DSFA Panel Number

Address

Doctor's Official Stamp

Data Protection and Freedom of Information

We, the Department of Social and Family Affairs will treat all information and personal data which you give as confidential. We will only disclose it to other 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.

63,500K 04-05 Edition: April 2005