Social Welfare Services
CR 1

Data Classification
Confidential

Application form for
Carer's Allowance

How to complete this application form.

- 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.
- You need a Personal Public Service Number (PPS No.) 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 **Parts 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.welfare.ie**.

You should apply for Carer's Allowance as soon as you start caring for someone.

How to fill 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: MURPHY

4. First name(s): MAUREEN

5. Your first name as it appears on your birth certificate: MARY

6. Birth surname: MCDERMOTT

7. Your mother's birth surname: KELLY

8. Your date of birth: 28 02 1970
D D M M Y Y Y Y

Contact Details

9. Your address:
1 NEW STREET
OLD TOWN
CO DONEGAL

10. Your telephone number:
0861234567
MOBILE
0170430000
LANDLINE

11. Your email address: MMURPHY@WELFARE.IE

SAMPLE

Application form for

Carer's Allowance

Social Welfare Services
CR 1

Data Classification
Confidential

Part 1 — Your own details (Carer's Details)

1. **Your PPS No.:**
2. **Title:** (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other
3. **Surname:**
4. **First name(s):**
5. **Your first name as it appears on your birth certificate:**
6. **Birth surname:**
7. **Your mother's birth surname:**
8. **Your date of birth:** D D M M Y Y Y Y

Contact Details

9. **Your address:**
10. **Your telephone number:** MOBILE / LANDLINE
11. **Your email address:**

Declaration

I declare that all the information I have given on this form is accurate.

I will tell the Department when my means or circumstances change.

Signature (**not** block 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.

Part 1 continued — Your own details

12. 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)

13. If you are married, in a civil partnership or cohabiting, from what date?

D D M M Y Y Y Y

Part 2 — Your work and claim details

14. Are you getting any payment from this Department or the Health Service Executive?

☐ Yes ☐ No

If 'Yes', please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

15. If you are paying maintenance, please state:

Amount: € , . a week

16. If you are receiving maintenance, please state:

Amount: € , . a week

17. If you are getting a private or occupational pension from this country, please state:

Who pays this pension:

Your claim or reference number:

Amount: € , . a week

18. If you are getting a foreign social security pension, please state:

Name of country:

Your claim or reference number:

Amount: € , . a week

19. If you are getting a private or occupational pension from another country, please state:

Who pays this pension:

Your claim or reference number:

Amount: € , . a week

Your work and claim details

20. Are you taking part in any training course or further education?

☐ Yes ☐ No

21. If you are employed at present, please state:

Employer's name:

Employer's address:

Gross weekly earnings: € , . a week

22. If you are self-employed at present, please state:

Type of work you do:

Gross weekly earnings: € , . a week

Date you started self-employment: D D M M Y Y Y Y

23. Have you given up this work to provide full-time care and attention for the person(s) named in Part 8?

☐ Yes ☐ No

24. You can work for up to 15 hours a week outside the home. Do you intend to....?

(a) remain at work for up to 15 hours a week:

☐ Yes ☐ No

or

(b) return to work for up to 15 hours a week:

☐ Yes ☐ No

25. If you have savings or accounts in a bank, post office, building society, credit union or any other financial institution, please state:

Financial Institution 1

Name of financial institution:

Sort code:

Account number:

Current balance: € , .

Name of account holder:

Financial Institution 2

Name of financial institution:

Sort code:

Account number:

Current balance: € , .

Name of account holder:

Financial Institution 3

Name of financial institution:

Sort code:

Account number:

Current balance: € , .

Name of account holder:

Financial Institution 4

Name of financial institution:

Sort code:

Account number:

Current balance: € , .

Name of account holder:

26. If you own stocks, shares or investments, please state:

Name of company:

Number of shares held: ,

Share price: € , .

27. If you own or work a farm or land, please state:

Size of farm or land: acres

Net yearly income: € , .

'Net yearly income' is money you have made from the farm **after** deducting operating expenses.

28. If your farm or land is let, please state net yearly income from letting:

Net yearly income: € , .

29. If you have property apart from your home, please state:

Type of property:

Address of property:

'Property' would be an apartment, business property, another house or land other than that mentioned at question 27.

Current market value: € , , .

Mortgage outstanding: € , , .

Your work and claim details

30. If you have a room let in the property you are currently residing in, please state:

Weekly income: € ☐☐,☐☐☐.☐☐ a week

31. If you have any other income please give details in the space provided:

32. If you sold or transferred any property or business in the last 3 years, please give details in the space provided and attach a copy of the deed of transfer:

33. If you have moved from your home to live with the person who you are caring for, please give details in the space provided if your home is rented, occupied by other people or otherwise being used:

34. If you have recently sold your home to buy another, please outline the circumstances in the space provided and attach a copy of the deed of transfer:

Part 3 Habitual Residence Condition

35. What country were you born in?

36. What is your nationality?

37. Have you lived outside the Republic of Ireland for any period longer than three months within the last five years?

☐ Yes ☐ No

38. If 'Yes', when did you come to live in the Republic of Ireland?

D D M M Y Y Y Y

39. Are you legally entitled to reside in the Republic of Ireland?

☐ Yes ☐ No

Part 4 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:

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 5 Details of your qualified child(ren)

40. 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 No.:

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

Are they living with you? ☐ Yes ☐ No

Surname:

First name(s):

PPS No.:

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

Are they living with you? ☐ Yes ☐ No

Surname:

First name(s):

PPS No.:

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

Are they living with you? ☐ Yes ☐ No

Surname:

First name(s):

PPS No.:

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

Are they living with you? ☐ Yes ☐ No

Surname:

First name(s):

PPS No.:

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

Are they living with you? ☐ Yes ☐ No

Part 6 Your spouse's, civil partner's or cohabitant's details

41. Their PPS No.:

42. Title: (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

43. Their surname:

44. Their first name(s):

45. Their date of birth: D D M M Y Y Y Y

46. Their birth surname:

47. Their mother's birth surname:

48. 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.

49. If they are paying maintenance, please state:

Amount: € , . a week

50. If they are receiving maintenance, please state:

Amount: € , . a week

51. If they are getting a private or occupational pension from this country, please state:

Who pays this pension:

Their claim or reference number:

Amount: € , . a week

52. If they are getting a foreign social security pension, please state:

Name of country:

Their claim or reference number:

Amount: € , . a week

Part 7 continued

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

53. If they are getting a private or occupational pension from another country, please state:

Who pays this pension:

Their claim or reference number:

Amount: € , . a week

54. If they are employed at present, please state:

Employer's name:

Employer's address:

Gross weekly earnings: € , . a week

55. If they are self-employed at present, please state:

Type of work they do:

Gross weekly earnings: € , . a week

Date they started self-employment:

D D M M Y Y Y Y

56. If they have savings or accounts in a bank, post office, building society, credit union or any other financial institution, please state:

Financial Institution 1

Name of financial institution:

Sort code:

Account number:

Current balance: € , .

Name of account holder:

Financial Institution 2

Name of financial institution:

Sort code:

Account number:

Current balance: € , .

Name of account holder:

Part 7 continued

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

Financial Institution 3

Name of financial institution:

Sort code:

Account number:

Current balance: €

Name of account holder:

Financial Institution 4

Name of financial institution:

Sort code:

Account number:

Current balance: €

Name of account holder:

57. If they own stocks, shares or investments, please state:

Name of company:

Number of shares held:

Share price: €

58. If they own or work a farm or land, please state:

Size of farm or land: acres

Net yearly income: €

'Net yearly income' is money they have made from the farm **after** deducting operating expenses.

59. If their farm or land is let, please state net yearly income from letting:

Net yearly income: €

60. If they have property apart from their home, please state:

Type of property:

Address of property:

'Property' would be an apartment, business property, another house or land other than that mentioned at question 58.

Current market value: €

Mortgage outstanding: €

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

61. If they have a room let in the property they are currently residing in, please state:

Weekly income: € ☐, ☐☐☐. ☐☐ a week

62. If they have any other income please give details in the space provided:

63. If they sold or transferred any property or business in the last three years please give details in the space provided and attach a copy of the deed of transfer:

64. If they have moved from their home, please give details in the space provided if their home is rented, occupied by other people or otherwise being used:

65. If they have recently sold their home to buy another, please outline the circumstances in the space provided and attach a copy of the deed of transfer:

Part 8 Details of person you are caring for

66. Their PPS No.:

67. Title: (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

68. Their surname:

69. Their first name(s):

70. Their birth surname:

71. Their date of birth:

D D M M Y Y Y Y

72. Their address:

73. Their mother's birth surname:

74. Have you or anyone applied for Domiciliary Care Allowance for them?

☐ Yes ☐ No

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

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

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

☐ 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.

77. If the person stays overnight at a care facility or centre, please state:

Name of centre:

Address of centre:

Telephone number of centre:

LANDLINE

Number of days they attend: ☐ a week

Number of nights they attend: ☐☐ a week

Please attach letter of confirmation from day care centre.

Details of person you are caring for

78. Does the person you are caring for live with you?

☐ Yes ☐ No

If 'No', please state:

Number of hours you provide care: ☐☐ a day

Number of days you provide care: ☐ a week

Does anyone else live with the person you are caring for?

☐ Yes ☐ No

If 'Yes', please give details in the space provided.

The distance between the households: ☐☐ kilometres

Is there a direct phoneline between the households?

☐ Yes ☐ No

If 'No', please give details of other direct link in the space provided.

Details of daily duties you perform looking after this person:

Note

If you are caring for more than one person, also complete form CR 2 and send it to Carer's Allowance Section, Social Welfare Services, Ballinalee Road, Longford. You can get form CR 2 online at www.welfare.ie or from your local Social Welfare Office. If you are caring for more than two people please complete a CR 2 form for each additional person.

Part 9 Checklist

Have you enclosed the following?

— **Your and your spouse's, civil partner's or cohabitant's most recent payslips**
(if you or your spouse, civil partner or cohabitant were employed during the last 12 months)

— **Statements from financial institutions for the last 3 months**
(If you or your spouse, civil partner or cohabitant have money, investments or shares in a financial institution)

— **Letter from school or college**
(if you have child(ren) aged between 18 and 22 who are in full-time education)

— **Your last P60 or P45 if you have left work**

— **A statement from accountant if you or your spouse, civil partner or cohabitant is 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 spouse's, civil partner's or cohabitant's birth certificate**
(if applying for an increase for them)

— **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.

We do not accept photocopies - send only original certificates, if needed.

If your form is not fully complete or the documents required are not enclosed there may be a delay in deciding your claim for Carer's Allowance. You could lose payment if you do not apply as soon as you start caring.

Please remember to sign the Declaration in Part 1.

Send the completed application form and other documents to:

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

LoCall: 1890 92 77 70 (from the Republic of Ireland only)
If you are calling from outside the Republic of Ireland please call + 353 43 3340000

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 Protection, 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 Allowance

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 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 Allowance.

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 Allowance scheme may be reviewed at any time.

Signature (**not** block letters)

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

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.

Signature (**not** block letters)

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

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.

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 Allowance 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 Allowance 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 ALLOWANCE 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

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:

Medical Report

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 →	☐	☐	☐	☐	☐
Learning/Intelligence →	☐	☐	☐	☐	☐
Consciousness/Seizures →	☐	☐	☐	☐	☐
Balance/Co-ordination →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Manual Dexterity →	☐	☐	☐	☐	☐
Lifting/Carrying →	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting →	☐	☐	☐	☐	☐
Sitting/Rising →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing Stairs/Ladders →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

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 Allowance:** ☐

(ii) **Review:**

(iii) **DNRA:** ☐

(iv) **Not eligible for Carer's Allowance:** ☐

Give reasons:

Signed _____ **Medical Assessor**

Date:

D	D	M	M	2	0	Y	Y

Data Protection and Freedom of Information

We, the Department of Social Protection, 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.