



# Application form for Carer's Allowance

**You need a Personal Public Service Number (PPS Number) before you apply.**

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.
- Please do not strikethrough any of the boxes. Leave boxes blank if they do not apply to you. If no income, please enter **0** in each box.

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

**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 to 6**. 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 to 8 and Part 10**. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

**Carer:**

You also must complete **Section 1 in Part 10** of the medical report and get the person you are caring for to sign **Section 2 in Part 10** of the medical report.

**Doctor:**

Please fill in **Section 3 of Part 10**, which is the Medical Report section of the Care 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 Citizens Information Centre, your local Intreo Centre or your local Social Welfare Branch Office.

For more information, visit [www.gov.ie](http://www.gov.ie)

## 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 Number:	1	2	3	4	5	6	7	T											
2. Title: (insert an <b>X</b> 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 date of birth:	2	8		0	2		1	9	7	0									
	D	D		M	M		Y	Y	Y	Y									
8. Your mother's birth surname:	K	E	L	L	Y														

## Contact Details

9. Your address:	1		N	E	W		S	T	R	E	E	T							
	O	L	D		T	O	W	N											
	D	O	N	E	G	A	L		T	O	W	N							
County	D	O	N	E	G	A	L												
Eircode/Postcode	A	6	5	F	4	E	2												
10. Your telephone number:	O	N	E		N	U	M	B	E	R		P	E	R		B	O	X	
	MOBILE																		
	O	N	E		N	U	M	B	E	R		P	E	R		B	O	X	
	LANDLINE																		
11. Your email address:	O	N	E		C	H	A	R	A	C	T	E	R		P	E	R		
	B	O	X																

# SAMPLE

# Application form for Carer's Allowance



## Part 1

## Your own details (Carer's Details)

1. Your PPS Number:

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2. Title: (insert an X or specify)

Mr  Mrs  Ms  Other 

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3. Surname:

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4. First name(s):

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

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6. Birth surname:

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7. Your date of birth:

D	D	M	M	Y	Y	Y	Y		

8. Your mother's birth surname:

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## Contact Details

9. Your address:

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County

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Eircode/Postcode

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10. Your telephone number:

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MOBILE

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LANDLINE

11. Your email address:

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## Declaration

I declare that the information given by me on 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, that 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 (not block letters)

Date: 

D	D	M	M	Y	Y

**20**

Y	Y

--

Signature of witness (not block letters)

Date: 

D	D	M	M	Y	Y

**20**

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.**





**33.** Are you taking over the provision of care from someone else who is getting Carer's Allowance or Benefit?  Yes  No

If **Yes**, please state the previous carer's:

Surname: 

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First name(s): 

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**34.** State the date from which the responsibility for care has transferred to you:

D	D	M	M	Y	Y	Y	Y													

Please supply a letter from the previous carer confirming this.

**35.** Is the cared for person currently in a hospital or nursing home?  Yes  No

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

**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.

If the cared for person stays overnight at a care facility or centre, please state:

Name of centre: 

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Address of centre: 

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Telephone number of centre: 

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 LANDLINE

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

Please attach a letter of confirmation from the care centre.

**37.** Does anyone else live with the person you are caring for?  Yes  No

If **Yes**, give details below:

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

Yes  No

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

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 or be self-employed or engage in training or education courses up to a maximum of 18.5 hours per week outside your home.

39. Do you intend to:

Be at work for up to 18.5 hours a week outside your home?

Yes  No

Be self-employed for up to 18.5 hours a week outside your home?

Yes  No

Be engaged on a training or education course for up to 18.5 hours a week outside your home?

Yes  No

40. If you are currently working and/or studying outside your home, in excess of 18.5 hours a week, from what date will you be reducing the combined hours on these activities to 18.5 or less?

             
 D D    M M    Y Y Y Y

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

42. Are you currently employed or self-employed inside your home?

Yes  No

**43.** If you answered **Yes** at Questions 39 or 42, fill in the relevant details below:

Employer's name:

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Employer's address:


Type of work:

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Employer's phone number:

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MOBILE

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LANDLINE

Employer's email address:


Type of self-employment:

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Title of course:

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Location of course:

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If you are employed or are on a training or education course outside your home, enclose a statement from your Employer or Training provider showing the number of hours a week you will be working or attending and the date the hours were reduced to a maximum of 18.5 a week.

Also include your latest payslip, if employed.

Carer's Allowance is a means tested payment. You are obliged by law to declare all your means (financial resources) which includes money in cash, or in a financial institution, savings, shares, bonds, funds, property (other than your own home), foreign pensions, etc. Please include written evidence such as statements and payslips with your application. Failure to do so could result in a delay in processing your application.

You must also declare the means of your spouse, civil partner or cohabitant.





**48.** Are you getting a social security payment from another country?

Yes       No

If **Yes**, please state:

Name of country:

Your claim or reference number:

Amount: € ,  .  a week

Please attach the most recent payslip or letter from the Social Security Agency confirming the above amount and also provide a 3 month bank statement for the account to which this payment is made.

**49.** Are you getting an occupational pension?

Yes       No

If **Yes**, please state:

Employer's name:

Amount: € ,  .  a week

Please attach the most recent payslip or letter from the employer or pension fund confirming the above amount and also provide a 3 month bank statement for the account to which this payment is made.

**50.(a)** Are you taking part in any of the following courses or schemes? Insert **X** in the box as it applies to you and give the date you started:

- |  |   |
|--|---|
| <input type="checkbox"/> Community employment:                     | <input type="checkbox"/> Rural Social Scheme:         |
| <input type="checkbox"/> Area-Based Initiative:                    | <input type="checkbox"/> Back to Work Scheme:         |
| <input type="checkbox"/> Vocational Training Opportunities Scheme: | <input type="checkbox"/> Back to Education Allowance: |
| <input type="checkbox"/> SOLAS course or schemes:                  | <input type="checkbox"/> School or college:           |
| <input type="checkbox"/> Other course or scheme:                   |   |

Name of course or scheme:

Date course:      Started:      

Due to finish:         
    D D          M M          Y Y Y Y

**50.(b)** Please state what you get paid for doing this scheme or course:

€ ,  .  a week

**51.** Do you own stocks, shares (including shares in a creamery or Co-op, annuities, bonds, insurance policies) or investments in Ireland or another country?

Yes       No

If **Yes**, please state:

Name of company:

Number of shares held: ,

Their value: € ,  .

Please attach a statement to show details and current market value.

**52.** Do you have savings or accounts in a bank, post office, building society, credit union or any other financial institution in Ireland or another country?

Yes  No

If **Yes**, please state:

**Financial Institution 1**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

**Financial Institution 2**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

**Financial Institution 3**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

**Financial Institution 4**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):  
Name 1:

Name 2 (if any):

Attach an original statement for each account showing the last 3 months transactions.

If you have other accounts, you must give details of them to this department on a separate sheet of paper.

**53.(a)** Do you own or share in the ownership of property apart from your home?  
 Yes  No

If **Yes**, 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 47.

Ownership percentage: .  %

Current market value: € , , .

Please provide a valuation from an authorised auctioneer or valuer.

Rent from this property: € , .  a week

Outstanding mortgage on property: € , , .

If mortgaged please attach a recent statement from lending institution.

**Note:** A separate sheet of paper should be used for details of any additional properties that you have.

**53.(b)** If you have a room let in the property you are living in now, please state:

Weekly income: € , .  a week

**54.** Is a separated or former spouse or civil partner or former cohabitant paying all or part of your accommodation costs by contributing to your rent or mortgage in place of or in addition to maintenance?  
 Yes  No

If **Yes**, please state:  
Amount: € , .  a week

**55.** Do you expect to receive any additional income or money in the coming 12 months from any other source(s)? (For example, a claim for compensation arising out of an accident or injury, sale of property, etc.)?  Yes  No

If **Yes**, please give details in the space below. If in doubt, you should disclose it here and we will determine if it affects your entitlement.

**56.** Do you have any other income from Ireland or another country?

Yes  No

If **Yes**, please give details in the space below. If in doubt, you should disclose it here and we will determine if it affects your entitlement.

**57.** Did you sell or transfer property or business in the last three years?

Yes  No

If **Yes**, please give details in the space below and attach a copy of the deed of transfer.

**58.** Did you recently sell your home to buy another?

Yes  No

If **Yes**, please outline the circumstances in the space provided and attach supporting documentary evidence from your solicitors regarding the financial transaction.

**Part 4**

**Habitual Residence Condition**

**59.**What country were you born in?

**60.**What is your nationality?

**61.**When did you come to live in Ireland?     
D D M M Y Y Y Y

**62.**If you are not an EEA National, do you hold a current:

Irish Residence Permit (Stamp 4):  Yes  No

Irish Employment Permit (Stamp 1):  Yes  No

Student Visa (Stamp 1A, Stamp 2A or Stamp 3):  Yes  No

Other?  Yes  No

The European Economic Area (EEA) comprises of the member states of the European Union together with Iceland, Norway and Liechtenstein and Croatia.

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

If **Yes**, to any of the above, please enclose your original permit and your original letter from the Department of Justice which sets out the reasons you have been granted permission to reside in Ireland.

**63.**Do you have an Irish Residency Permit (IRP) ?  Yes  No

If **Yes**, please attach a verified copy of same (your local Intreo Centre or your local Social Welfare Branch Office can photocopy it for you and verify that they saw the original).

64. How long do you intend to stay in Ireland?

0-1 year

1-2 years

3-5 years

over 5 years

65. Have you lived outside of Ireland for any period longer than 3 months within the last 5 years?

Yes

No

If **Yes**, please give details of where you lived in the space provided.

**Country 1**

Country:

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From:

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To:

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D D

M M

Y Y Y Y

The reason that you lived there:

**Country 2**

Country:

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From:

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To:

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D D

M M

Y Y Y Y

The reason that you lived there:

## Part 5

## 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. Please complete one option below.

### Financial Institution

You will find the following details printed on statements from your financial institution.

Name of financial institution:	<input type="text"/>
Bank Identifier Code (BIC):	<input type="text"/>
International Bank Account Number (IBAN):	<input type="text"/>
Name(s) of account holder(s):	<input type="text"/>
Name 1:	<input type="text"/>
Name 2 (if any):	<input type="text"/>

### Post Office

Please enter below the name and address of the post office where you wish to collect your payment.

Post office name and address:	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>

## Part 6

## Details of your children

66. Do you have children living with you?

Yes  No

If **Yes**, how many are under 18 and aged between 18 - 22 in full-time education?

under age 18  aged 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:

#### Child 1

Surname:	<input type="text"/>
First name(s):	<input type="text"/>
PPS Number:	<input type="text"/>
Date of birth:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	D D M M Y Y Y Y

Do they normally live with you?

Yes  No



**Child 2**

Surname:

First name(s):

PPS Number:

Date of birth:

D D      M M      Y Y Y Y

Do they normally live with you?  
 Yes       No

**Child 3**

Surname:

First name(s):

PPS Number:

Date of birth:

D D      M M      Y Y Y Y

Do they normally live with you?  
 Yes       No

**Child 4**

Surname:

First name(s):

PPS Number:

Date of birth:

D D      M M      Y Y Y Y

Do they normally live with you?  
 Yes       No

**Child 5**

Surname:

First name(s):

PPS Number:

Date of birth:

D D      M M      Y Y Y Y

Do they normally live with you?  
 Yes       No

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

## Part 7

## Your spouse's, civil partner's or cohabitant's details

67. Their PPS Number:

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68. Title: (insert an X or specify)

Mr.  Mrs.  Ms.  Other 

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69. Their surname:

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70. Their first name(s):

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71. Their birth surname:

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72. Their date of birth:

D	D	M	M	Y	Y	Y	Y

73. Their address:

Only provide this if you are married or in a civil partnership and do not live together.


74. Their mother's birth surname:

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## Part 8

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

Please complete the remainder of this section.

If no income, please enter **0** in each box.

75. Are they receiving maintenance?

Yes  No

If **Yes**, please state:

Amount: € 

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 a week

**Please provide a copy of the maintenance agreement.**

76. Are they paying maintenance?

Yes  No

If **Yes**, please state:

Amount: € 

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 a week

**Please provide a copy of the maintenance agreement.**

77. Are they currently employed?

Yes  No

If **Yes**, please state:

Their employer's name: 

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Their employer's address: 

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Their gross weekly earnings:

€ 

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 a week

**Please attach latest payslip.**

**78.** Are they or have they been self-employed?

Yes  No

If **Yes**, please state:

Type of work they do or did:

Date self-employment started:

D D M M Y Y Y Y

Net yearly income: €     ,     .   a year

**Net yearly income** is money you have made from self-employment after deducting operating expenses.

Are they still self-employed:  Yes  No

If **No**, please state date self-employment ended:

D D M M Y Y Y Y

**79.(a)** Do they own, share in the ownership, work or rent a farm or land?

Yes  No

If **Yes**, please state:

Size of farm or land:     Acres **OR**    Hectares

Herd or flock number:

Net yearly income from farm or land: €   ,     .

**Net yearly income** is money they have made from the farm after deducting operating expenses. You must enclose their most recent Statement of Receipts from the Department of Agriculture.

**79.(b)** If their farm or land is let, please state net yearly income from letting:

Net yearly income: €   ,     .

**80.** Are they getting a social security payment from another country?

Yes  No

If **Yes**, please state:

Name of country:

Their claim or reference number:

Amount: €  ,     .   a week

Please attach their most recent payslip or letter from their Social Security Agency confirming the above amount and also provide a 3 month bank statement for the account to which this payment is made.

**81.** Are they getting an occupational pension?

Yes  No

If **Yes**, please state:

Employer's name:

Amount: €  ,     .   a week

Please attach their most recent payslip or letter from their employer or pension fund confirming the above amount and also provide a 3 month bank statement for the account to which this payment is made.

**82.(a)** Are they taking part in any of the following courses or schemes? Insert an 'X' in the box as it applies to them and give the date they started:

- |  |   |
|--|---|
| <input type="checkbox"/> Community employment:                     | <input type="checkbox"/> Rural Social Scheme:         |
| <input type="checkbox"/> Area-Based Initiative:                    | <input type="checkbox"/> Back to Work Scheme:         |
| <input type="checkbox"/> Vocational Training Opportunities Scheme: | <input type="checkbox"/> Back to Education Allowance: |
| <input type="checkbox"/> SOLAS course or schemes:                  | <input type="checkbox"/> School or college:           |
| <input type="checkbox"/> Other course or scheme:                   |   |

Name of course or scheme:

Date course: Started:

Due to finish:

D D M M Y Y Y Y

**82.(b)** Please state what they get paid for doing this scheme or course:

€ ,    .   a week

**83.** Do they own stocks, shares (including shares in a creamery or Co-op, annuities, bonds, insurance policies) or investments in Ireland or another country?

Yes  No

If **Yes**, please state:

Name of company:

Number of shares held: ,

Their value: € ,    .

**Please attach a statement to show details and current market value.**

**84.** Do they have savings or accounts in a bank, post office, building society, credit union or any other financial institution in Ireland or another country?

Yes  No

If **Yes**, please state:

**Financial Institution 1**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € ,    .

Is this a joint account?  Yes  No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

**Financial Institution 2**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):  
Name 1:

Name 2 (if any):

**Financial Institution 3**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):  
Name 1:

Name 2 (if any):

**Financial Institution 4**

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this a joint account?  Yes  No

Name(s) of account holder(s):  
Name 1:

Name 2 (if any):

**Attach an original statement for each account showing the last 3 months transactions.**

**If you have other accounts, you must give details of them to this department on a separate sheet of paper.**

85.(a) Do they own or share in the ownership of property apart from your home?

Yes  No

If **Yes**, 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 79. 


Ownership percentage: 

--	--	--	--

 . 

--	--

 %

Current market value: € 

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 , 

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 , 

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 . 

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Please provide a valuation from an authorised auctioneer or valuer.

Rent from this property: € 

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 . 

--	--

 a week

Outstanding mortgage on property: € 

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 , 

--	--	--	--

 , 

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 . 

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If mortgaged please attach a recent statement from lending institution.

**Note:** A separate sheet of paper should be used for details of any additional properties that they have.

85.(b) If they have a room let in the property they are living in now, please state:

Weekly income: € 

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 , 

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 . 

--	--

 a week

86. Is a separated or former spouse or civil partner or former cohabitant paying all or part of their accommodation costs by contributing to their rent or mortgage in place of or in addition to maintenance?  Yes  No

If **Yes**, please state:

Amount: € 

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 , 

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 . 

--	--

 a week

87. Do they expect to receive any additional income or money in the coming 12 months from any other source(s)? (For example, a claim for compensation arising out of an accident or injury, sale of property, etc.)?  Yes  No

If **Yes**, please give details in the space below. If in doubt, you should disclose it here and we will determine if it affects your entitlement.

--

**88.** Do they have any other income from Ireland or another country?

Yes  No

If **Yes**, please give details in the space below. If in doubt, you should disclose it here and we will determine if it affects your entitlement.

**89.** Did they sell or transfer property or business in the last three years?

Yes  No

If **Yes**, please give details in the space below and attach a copy of the deed of transfer.

**90.** Did they recently sell your home to buy another?

Yes  No

If **Yes**, please outline the circumstances in the space provided and attach supporting documentary evidence from your solicitors regarding the financial transaction.

## Have you enclosed the following?

Tick (√)	Checklist
	Have you signed the Declaration in <b>Part 1</b> ?
	If you were born, married or entered a civil partnership or union outside of Ireland, have you enclosed your birth certificate, your marriage certificate or civil partnership or union registration certificate, the birth certificate of a spouse, civil partner or cohabitant (if any) and your children's (if any) birth certificate(s) if you are not getting Child Benefit for them?
	If the cared for person stays overnight in a Care Facility/Centre, have you enclosed a letter of confirmation from the Care Facility/Centre?
	If you or a spouse, civil partner or cohabitant are working, have you enclosed your latest payslip(s)?
	If you intend to be working outside your home while getting the allowance, have you enclosed a letter from your employer showing the number of hours you will be working and the date the hours were or will be reduced to 18.5 or less a week?
	If you are engaged on an Education or Training course, have you enclosed a letter from the Training Provider showing that the number of hours you will be engaged on the course outside your home is or will be 18.5 hours a week or less?
	Have you disclosed the balance in every account you or a spouse, civil partner or cohabitant have in a financial institution and enclosed statements showing the last 3 months' transactions?
	If you or a spouse, civil partner or cohabitant are getting a Social Security payment from another Country, have you included payment slip(s)?
	If you or a spouse, civil partner or cohabitant are getting an Occupational Pension, have you included payment slip(s)?
	If you or a spouse, civil partner or cohabitant own or share in the ownership of stocks or shares, have you enclosed a statement showing their details and their current market value?
	If you or a spouse, civil partner or cohabitant own or share in the ownership of any property apart from your home, have you enclosed a valuation from an authorised auctioneer or valuer? If the property is mortgaged, have you enclosed a recent statement from the lending institution?
	If you or a spouse, civil partner or cohabitant is receiving maintenance, have you enclosed a copy of the maintenance agreement?
	If you or a spouse, civil partner or cohabitant are paying maintenance, have you enclosed a copy of the maintenance agreement?
	If you or a spouse, civil partner or cohabitant have sold or transferred a property or business in the past 3 years, have you enclosed a copy of the deed of transfer?
	If you or a spouse, civil partner or cohabitant have sold a home to buy another, have you attached supporting documentary evidence from your solicitors about the financial transaction?



Tick (√)	Checklist continued
	If you have an Irish Residency Permit (IRP), have you attached a verified copy?
	Have you attached written confirmation from a school/college to confirm the attendance in full-time day education of any child aged between 18 and 22?
	If you or a spouse, civil partner or cohabitant are self-employed, have you enclosed the most recent set of accounts of the business or farm.
	If you or a spouse, civil partner or cohabitant are involved in farming, have you enclosed the most recent Statement of Receipts from the Department of Agriculture?
	If you are taking over care from another carer, have you enclosed a letter from the previous carer confirming the date that your responsibility for the care will start?

**Note:** Original certificates/documentation are required in most cases. These can be brought directly to your local Intreo office along with your application form. The staff in the Intreo will copy the certificates and return the originals to you.

## Please remember to sign the Declaration in Part 1.

If you have any difficulty in filling in this form, please contact your local Citizens Information Centre, your local Intreo Centre or your local Social Welfare Branch Office.

### Send this completed application form to:

**Carer's Allowance Section**  
 Department of Social Protection  
 Social Welfare Services  
 Government Buildings  
 Ballinalee Road  
 Longford

Telephone: (043) 334 0000  
 LoCall: 1890 92 77 70

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

**Note:** The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

**Important: If you do not claim within 7 days you could lose benefit.**

### 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/benefits. Personal data may be exchanged with other Government departments/agencies where provided for by law. Our data protection policy is available at [www.gov.ie/dsp/privacystatement](http://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.

## Note to carer

### Important

The following Care Report is in three parts.

You should complete **Section 1** which allows you to tell us about the care requirements of the person you are caring for.

Then have **Section 2** completed and signed by the person being cared for (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 by the care recipient as long as the evidence from the doctor supports that they are unable to sign or that it would be detrimental to them to sign it.

You must then pass this entire Care Report (Part 10) to the doctor of the person being cared for. The doctor completes **Section 3** and may return the form to you in a sealed envelope to keep their patient's medical details confidential.

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

Please make sure you return the Care Report (**Part 10**) form along with your application.



# Care Report for Carer's Allowance

## Part 10 continued

## Care Report

**Please state carer's:**

PPS Number:

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

Surname:

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

First name(s):

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

**Please state care recipient's:**

Surname:

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

First name(s):

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

## Section 1

**Please tell us about the care needs of the person being cared for in the following sections.**

### Mental Health

Does the person have a mental health condition?

Yes       No

Does the person have 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 their difficulties and what help they require.

### Communication

Does the person have difficulty with communication?

Yes       No

Does the person have difficulty hearing?

Yes       No

If **Yes** to any of the above, describe what help they require.

## Vision

Does the person have difficulty with vision?

Yes  No

If **Yes** to the above, describe what help they require.

## Feeding

Does the person have difficulty with eating or drinking?

Yes  No

If **Yes**, describe what help they require.

## Bathing or Showering

Does the person have difficulty with bathing or showering?

Yes  No

If **Yes**, describe what help they require.

## Dressing

Does the person have difficulty with dressing?

Yes  No

If **Yes**, describe what help they require.

## Toileting and Continence

Does the person need help to use the toilet?

Yes  No

Does the person have loss of bladder control?

Yes  No

Does the person have loss of bowel control?

Yes  No

Does the person use continence aids or equipment?

Yes  No

If **Yes** to any of the above, describe what help they require.

## Mobility

Does the person have difficulty with walking or mobility?

Yes  No

If **Yes** to any of the above, describe what help they require.

## Sleeping

Does the person have difficulty sleeping?

Yes  No

If **Yes**, describe what help they require.

**Additional needs**

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

Examples might include:

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

Describe what help they require.

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?

If you want to provide further information, add sheet(s) of paper with your PPS Number on. Please put the appropriate heading before each piece of additional information, for example “mental health”, “dressing”, “mobility” and so on.

## Section 2

## Carer's details

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

Surname:

First name:

PPS Number:

## Previous carer's details

If there has been a carer in receipt of carer's allowance for this care recipient, please provide the name of the last carer below.

Surname:

First name:

**Care recipient's declaration and authorisation**

I hereby confirm that I need **full-time care** and **attention** and the carer named above is providing full-time care and attention to me. I will inform the Department of Social Protection if this changes.

I permit my doctor(s) to provide you, the Department of Social Protection, with medical information that you need for this application for Carer's Allowance.

I understand that I may need to attend a medical examination, from time to time, and my right to care under the Carer's Allowance scheme may be reviewed at any time.

**Signature** (not block letters) of the person receiving care

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 medical professional to give us medical information that we need to decide your eligibility to the Carer's Allowance scheme.

A Medical Assessor will review the medical information and will treat it in strictest confidence. Although a confidential report, both medical and non-medical staff will need to handle this report in order to process your claim.

## Section 3 - Medical Report

This section 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 department at the telephone number below.

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

**Note:**

The term "age appropriate" applies to young children who would normally, by reason of age, be dependent for care in this activity.

If you have any queries, please contact Carer's Allowance Section at:

Telephone: (043) 334 0000

LoCall: 1890 927 770

If you are calling from outside of Ireland please call + 353 43 334 0000



Section 3 - Medical Report

Patient details

Please use BLOCK letters

Surname:

First name:

Address:

Date of birth:

    
D D M M Y Y Y Y

PPS Number:

Your patient since:

    
D D M M Y Y Y Y

Diagnosis(es)

Diagnosis:	Date:	Diagnosis:	Date:
1.		5.	
2.		6.	
3.		7.	
4.		8.	

ICD10 Code(s):

Please give details of the following:

Relevant medical or surgical history and clinical findings:

Hospital admissions:

(Recent or relevant dates and approximate duration)

**Section 3 - Medical Report**

Attending Specialist(s):  
(Name, speciality and frequency of attendance)

Other treatment(s):

**Current medications:**

Medication:	Dose:	Medication:	Dose:
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please describe your patient's care needs under the following headings if they are impaired or dependent.

**Cognition**

- Normal       Impaired
- Yes             No
- Yes             No

Dementia:

General learning disability:

Results of MMSE, MOCA or equivalent:

State full scale IQ:

Other – please state:

Section 3 - Medical Report

Mental Health

Normal     Impaired

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

Consciousness or Seizures

Normal     Impaired

Epilepsy:

Yes     No

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

Please describe any other causes of impaired consciousness:

Frequency:

Date of last episode:

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

Speech and hearing

Normal/Age appropriate     Impaired

Describe impairment and please state the support and care required:

Section 3 - Medical Report

Vision

Registered Blind (NCBI):

Normal  Impaired

Yes  No

Visually impaired:

Yes  No

Corrected visual acuity:

**Right:**  
 /

**Left:**  
 /

Visual fields:

Other:

Feeding

Independent/Age appropriate

Dependent

Please describe, for example, prescribed diet / assisted feeding / NG / PEG:

Bathing or showering

Independent/Age appropriate

Dependent

Please describe:

Dressing

Independent/Age appropriate

Dependent

Please describe:

## Section 3 - Medical Report

## Continence or toileting

 Independent/Age appropriate Dependent

Please describe bowel, bladder function. For example, double incontinence, stoma or continence aids:

## Mobility

 Independent/Age appropriate Dependent

Please describe care required. For example, needs assistance, walking aids, immobile or wheelchair dependent:

## Specific conditions

Is your patient receiving palliative care or terminally ill?

 Yes  No

Other Information / Care Needs / Concerns:

How long do you expect these care needs to continue?

 Less than 12 months 12-24 months Indefinitely Unknown

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

Section 3 - Medical Report

Doctor's name:

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DSP panel number:

--	--	--	--	--

IMC number:

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

Address:


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Doctor's Signature (not block letters)

<b>Doctor's official stamp</b>
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Date:

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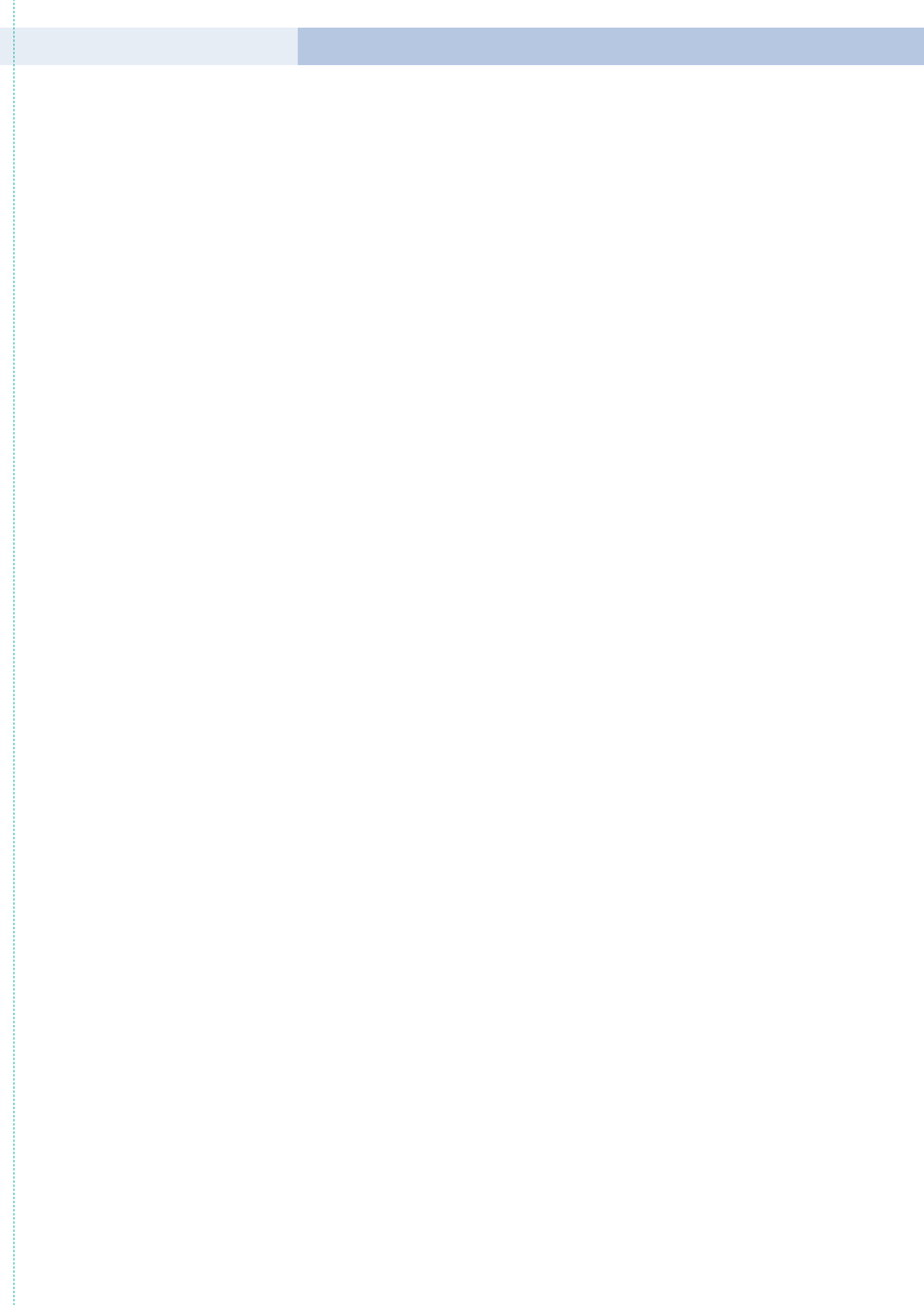
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Y Y Y Y



## **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/benefits. Personal data may be exchanged with other Government Departments/Agencies where provided for by law. Our data protection policy is available at [www.gov.ie/dsp/privacystatement](http://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.