



Application form for Carer's Support Grant

What is the Carer's Support Grant?

The Carer's Support Grant is an annual payment made to carers who get Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance (DCA). It can also be paid to certain other carers providing full-time care. Carers can use the grant in whatever way they wish.

Often carers use the grant to pay for respite care.

Who can get the Carer's Support Grant?

You automatically qualify for the Carer's Support Grant if you get Carer's Allowance, Carer's Benefit, or Domiciliary Care Allowance. If you are not getting any of these payments, you may still qualify if you meet the conditions below.

To qualify you must:

- be 16 or over;
- be ordinarily resident (live) in the Irish State – with the person;
- be caring full time for the person for a continuous period of at least six months; **and** this must include the first Thursday in June of the year you are claiming for.

During the 6 month caring period you cannot:

- receive Jobseeker's Benefit or Allowance,
- sign on for credited contributions, **or**
- work more than 15 hours a week (18.5 hours a week from January 2020) outside of home.

How do I apply?

If you are getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance, **you do not need to apply for the Carer's Support Grant. We will automatically pay you every June.** If you are not getting any of these payments fill in CSG1 form for each person you are caring for. You need a Personal Public Service Number (PPS Number) before you apply.

How to complete this application form

- Please tear off this page and use 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, this is **Part 1** to **Part 3**.
- The person you are caring for should sign **Part 5** confirming that they require care.
- You should then get the doctor to complete the medical report.
- Put a line through any box if it does not apply to you.
- You as the carer should sign the Declaration in **Part 1** after you complete the form.
- The person you are caring for must sign the Authorisation in **Part 5**.
- The doctor of the person receiving care from you must also sign **Part 5**.

If you need any help to complete this form, please contact your local Citizen Information Centre, your local Intreo Centre or your local Social Welfare Office or the Carer's Support Grant Section at (043) 334 0000

For more information, visit 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 **X** or specify Mr. Mrs. Ms. 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. Your date of birth:

2	8			0	2			1	9	7	0				
D	D			M	M			Y	Y	Y	Y				

Contact Details

7. 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			Postcode							
8. Your telephone number:

O	N	E		N	U	M	B	E	R		P	E	R		B	O	X		
---	---	---	--	---	---	---	---	---	---	--	---	---	---	--	---	---	---	--	--
9. Your email address:

O	N	E		C	H	A	R	A	C	T	E	R		P	E	R			
B	O	X																	

SAMPLE

10. What country were you born in?

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

11. Are you?

<input type="checkbox"/> Single	<input type="checkbox"/> Cohabiting
<input type="checkbox"/> Married	<input type="checkbox"/> In a Civil Partnership
<input type="checkbox"/> Separated	<input type="checkbox"/> A surviving Civil Partner
<input type="checkbox"/> Divorced	<input type="checkbox"/> A former Civil Partner
<input type="checkbox"/> Widowed	(you were in a Civil Partnership that has since been dissolved)

12. Are you getting any of the following:

Carer's Allowance? Yes No

Carer's Benefit? Yes No

Domiciliary Care Allowance? Yes No

If you were getting one of these three payments on the 1st Thursday in June of the year in question, you do not have to complete this form, you will get the Grant automatically for that year. Only one grant is paid for each person receiving full time care and attention.

If **No**, please state:

Have you ever applied for Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance?

Yes No

If **Yes**, please state:

What year did you apply?

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Y Y Y Y

13. Are you, or have you been, employed or self-employed (includes farming) outside the home in the last 2 years?

Yes No

If **Yes**, please state:

Your occupation:

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Periods of employment and how many hours worked each week, please insert dates below:

Period of employment 1

From:

D	D
---	---

M	M
---	---

Y	Y	Y	Y
---	---	---	---

To:

D	D
---	---

M	M
---	---

Y	Y	Y	Y
---	---	---	---

Hours:

--	--

 a week

Period of employment 2

From:

D	D
---	---

M	M
---	---

Y	Y	Y	Y
---	---	---	---

To:

D	D
---	---

M	M
---	---

Y	Y	Y	Y
---	---	---	---

Hours:

--	--

 a week

Part 2

Your payment details

Please choose one payment option below.

NOTE: You must have a Social Welfare or Public Services Card to collect your payment at a Post Office.

Financial Institution

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

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Post Office

Post Office address:

Part 3

Details of person you are caring for

16. Their PPS Number:

17. Their surname:

18. Their first name(s):

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

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

21. When did you start providing full-time care for them?
D D M M Y Y Y Y

22. Have you been or are you likely to be providing full-time care and attention for a continuous period of at least 6 months? Yes No

IMPORTANT: Carer's Support Grant is paid only where the **6 month period of care includes the first Thursday in June.** For more information, visit www.gov.ie.

23. Is anyone else getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance for them? Yes No

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

Note to carer

Remember

You do not need to apply for the Carer's Support Grant if you are getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance and are caring full time for the person for a continuous period of at least six months which includes the first Thursday in June of the year you are claiming for. The Carer's Support Grant is paid automatically to anyone in these circumstances.

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

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

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

Medical Report for Carer's Support Grant



Part 5

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

Authorisation

I need **full-time care** and **attention** and the person named in **Part 1** of this form 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 Support Grant.

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 Support Grant scheme may be reviewed at any time.

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Date:

--	--

D D

--	--

M M

2	0		
---	---	--	--

Y Y Y Y

Signature (not block letters) of the person receiving care

If you cannot sign, make a mark and have it witnessed. A witness cannot be the carer or a member of the carer's household.

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Date:

--	--

D D

--	--

M M

2	0		
---	---	--	--

Y Y Y Y

Signature (not block letters)

Note

In signing the authorisation above, you allow your doctor to give us the medical information we need to decide if you qualify for care under the Carer's Support Grant scheme.

One of our Medical Assessors will review the medical information and will treat it in the strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

Section B

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess if they qualify for care under the Carer's Support Grant scheme, please complete the medical report on the following pages. The medical information provided will be reviewed by one of our Medical Assessors, who will treat it in the 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 Support Grant Section** at (043) 334 0000

Note:

The carer should already have filled Parts 1 and 2 of the application form. The person being cared for must have completed Section A of this medical report.

The completed Medical report form should be returned by the doctor to the carer who will send it, along with the application form, to the:

Carer's Support Grant Section

Government Buildings
Ballinalee Road
Longford
N39 E4EO

Telephone: (043) 334 0000

LoCall: 1890 92 77 70

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

Section B continued

1. Patient details

(please use Block capitals)

Surname:

Grid for Surname

First name:

Grid for First name

Address:

Grid for Address

Date of birth:

Grid for Date of birth with labels D D M M Y Y Y Y

PPS Number:

Grid for PPS Number

Mobile telephone Number:

Grid for Mobile telephone Number

The patient may be contacted by text message in relation to a medical assessment.

Occupation:

Grid for Occupation

2(a). Your patient since:

Grid for 2(a) with labels D D M M Y Y Y Y

2(b). How often does the patient visit your surgery?

Weekly Monthly Less often

3. Diagnosis (use BLOCK CAPITALS):

Grid for Diagnosis

4. ICD10 Code(s):

Grid for ICD10 Code(s)

5. Date condition started:

Grid for Date condition started with labels 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

7. Please give:

Medical history

Text area for Medical history

Surgical/Obstetrical history

Text area for Surgical/Obstetrical history

Attach relevant reports/test results/referrals

Hospital admissions

Date of discharge:

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

Relevant investigations

8. Please give details if any of the following apply:

Attending a specialist

On medication

Other treatment

Clinical findings

9. Pregnant:

Yes No

If Yes, give EDD:

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

Please attach any relevant reports/results of investigations.

Additional Information:

For Official use Only

(i) Eligible for Carer's Support Grant:

(ii) Review:

(iii) DNRA:

(iv) Not eligible for Carer's Support Grant:

Give reasons:

Signed _____ Department Medical Assessor

Date:

D D

M M

2 0

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 or benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at www.gov.ie/dsp/privacystatement or as a hard copy.

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