Rialtas na hÉireann
Government of Ireland

Application form for Carer's Benefit

Social Welfare Services

CARB1

Data Classification R

The quickest and easiest way to apply for Carer's Benefit is on MyWelfare, a verified MyGovID is required.

You can go directly to the Carer's Benefit application on MyWelfare by scanning this QR code or by visiting **www.MyWelfare.ie/carersbenefit.**

What is Carer's Benefit?

Carer's Benefit is a payment for people who leave work or reduce their hours to care for a person in need of full-time care. Carer's Benefit is based on your social insurance (PRSI) contributions. It is not a means tested payment, but there is a limit to how much you can earn from employment or self-employment.

How should this form be completed?

There is an example on the back of this page that can be used as a guide for completing. Please make sure that:

- the form is completed with a **black** ballpoint pen, using capital letters and placing an **X** in the relevant boxes;
- you complete **Section 1** and **Section 2.** Answer all questions that apply to you;
- **Section 3** is completed by the doctor of the person you are caring for;
- **Section 4** is completed by your employer, if relevant;
- **Section 5 i**s completed by your education or training course provider, if relevant.

How do I submit the completed form?

You should send the completed form by post to:

Carer's Benefit Section,
Department of Social Protection,
Government Buildings,
Ballinalee Road,
Longford,
N39 E4E0

How can I get help and further information?

If you need any help to complete this form, please contact us by phone at **0818 927 770** or **043 334 0000,** or by email at **CarersBenefit@welfare.ie**. You can also contact your local Intreo Centre, Social Welfare Branch Office or any Citizens Information Centre. The name and address of your local Intreo Centre or Social Welfare Branch Office can be found by visiting **www.gov.ie/intreocentres**

For more information please visit **www.gov.ie/carersbenefit**

How to fill in this form

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

Part 1 Your details

1. PPS number: 1234567T

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

3. Surname: MURPHY

4. First names: MAUREEN

5. Birth surname: MORAN

6. Date of birth: 28 02 1970
D D M M Y Y Y Y

7. Address: 1 NEWSTREET
OLD TOWN
DONEGAL TOWN
County DONEGAL Eircode A65F4E2

8. Telephone number: 0881234567

9. Email address: MMURPHY@WELFARE.IE

SAMPLE

Section 1
Application form for Carer's Benefit

Part 1 Your details

1. PPS number:

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

3. Surname:

4. First names:

5. Birth surname:

6. Date of birth:

D D M M Y Y Y Y

7. Address:

County Eircode

8. Telephone number:

9. Email address:

10. What is your status?

- ☐ Single
- ☐ Cohabitant, married or in a civil partnership
- ☐ Separated, divorced or a former civil partner
- ☐ Widowed or a surviving civil partner

Part 2 Your employment and training details

Employment

11. Have you been **employed** at any time in the last 6 months? ☐ Yes ☐ No

If **no**, proceed to **question 14**.

12. Please provide the name of any employer or business you've worked for within the last 6 months:

Employer 1:

Employer 2:

Employer 3:

Note: You will be required to provide a completed Employer's Declaration (**CARB-ER1**) for each employment you have had within the last 6 months. The form is attached in this document.

13. Do you make payments towards private health insurance? ☐ Yes ☐ No

If **yes**, how much do you pay towards private health insurance? € ☐☐,☐☐☐.☐☐ a week

Self-employment

14. Have you been **self-employed** at any time in the last 6 months? ☐ Yes ☐ No

If **no**, proceed to **question 24**.

15. What type of self-employment work have you done in the last 6 months?

Type of work:

16. Please confirm the date you first started self-employment: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

17. What year did you submit your most recent Income Tax Return and Self-Assessment? 2 0 ☐☐ (Y Y Y Y)

Note: If you haven't submitted an Income Tax Return and Self-Assessment yet, please enter the current year.

Your employment and training details

18. Please confirm the number of self-employment hours you worked during the above submission year: ☐☐.☐ a week

19. Have you been employed for at least 16 hours each week, or 32 hours every fortnight, for any 8 weeks within the last 6 months? ☐ Yes ☐ No

Note: These 8 weeks do not have to be continuous or consecutive weeks. You can find out more about the employment criteria for Carer's Benefit on **www.gov.ie/carersbenefit**

20. Please confirm the number of self-employment hours you currently work: ☐☐.☐ a week

21. Do you intend to leave self-employment or reduce your hours if awarded Carer's Benefit? ☐ Yes ☐ No

If **yes**, please confirm the date you will leave self-employment or reduce your hours: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

22. Please confirm how many hours you intend to be engaged in self-employment if awarded Carer's Benefit. ☐☐.☐ a week

23. Do you know what date you intend to return to self-employment or return to your current hours? ☐ Yes ☐ No

If **yes**, please confirm the date you will return to self-employment or return to your current hours: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

Training and Education

24. Are you currently engaged in training or education? ☐ Yes ☐ No

If **yes**, you will be required to provide a completed Education Declaration (**CAR-ED1**). The form is attached in this document.

25. Do you intend to engage in employment, self-employment, training or education while in receipt of Carer's Benefit? ☐ Yes ☐ No

If **yes**, what care arrangements will be made while you are engaged in employment, self-employment, training or education?

Part 3 Your children's details

Child Support Payment

The Child Support Payment is an increase on your social welfare payment for a child dependant.

If you are in a relationship and you would like to apply for the Child Support Payment, your partner's income must be **less** than €400 before tax each week to be considered eligible. You can find out more about the Child Support Payment on **www.gov.ie/csp**

26. Do you have any dependent children? ☐ Yes ☐ No

Note: You must live with or contribute substantially to the maintenance or upkeep of a child aged 17 years or younger for them to be dependent. A child aged 18 and up to 22 years who is currently in full-time education may also be considered dependent.

If **no**, proceed to **Part 5**.

27. Would you like to apply for the child support payment for your dependent children? ☐ Yes ☐ No

If **no**, proceed to **Part 5**.

If **yes**, please state the child's:

Child 1

Surname:

First names:

PPS number:

Child 2

Surname:

First names:

PPS number:

Child 3

Surname:

First names:

PPS number:

Child 4

Surname:

First names:

PPS number:

Note: If needed, a separate sheet of paper can be used for details of any other children you may have.

Part 4 Your partner's details

This section should only be completed if you have a partner and you are applying for a Child Support Payment.

28. What is your partner's PPS number?

29. What is your partner's income each week before tax?

☐ €400 or more.

☐ From €0 to €399.

30. Does your partner earn income from employment or an employment scheme? ☐ Yes ☐ No

Note: This includes Community Employment (CE), Tús, and the Rural Social Scheme.

If **yes**, please state:

Name of your partner's current employer or employment scheme:

How much they earn each week before deductions: €

31. Is your partner self-employed? ☐ Yes ☐ No

If **yes**, please state:

Type of self-employment work your partner does:

How much they earn each week before deductions: €

32. Does your partner receive rental income? ☐ Yes ☐ No

If **yes**, please state:

How much rental income they receive each week: €

33. Does your partner have savings, investment property or capital worth over €20,000? ☐ Yes ☐ No

If **yes**, please state:

The total amount of money in savings, investments, property or capital that your partner has: €

Part 4 continued — Your partner's details

34. Does your partner receive income from any other source? ☐ Yes ☐ No

Note: This could include any other income such as maintenance, a trust fund, EU or UK state benefit or payment, or cash income.

If **yes**, please state:

Source of other income:

Your partner's average weekly income from this source: € , .

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.

Post Office

Post office name:

Address:

County Eircode

Note: You will need a Public Services Card (PSC) 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:

International Bank Account Number (IBAN):

Bank Identifier Code BIC:

Names of account holders:

Name 1:

Name 2, if any:

Part 6 Caring details

35. What is the PPS number of the person you are caring for?

36. What is their first name?

37. What is their surname?

38. What is their date of birth?

D D M M Y Y Y Y

39. Are you currently providing care to this person? ☐ Yes ☐ No

If **yes**, please state:

When **did** you start caring for this person?

D D M M Y Y Y Y

If **no**, please state:

When **will** you start caring for this person?

D D M M Y Y Y Y

Hours of Care

To qualify for Carer's Benefit, you must be providing at least 35 hours of care over a minimum 5 days each week.

Care hours should include all aspects of caring for a person who needs full-time care and continual supervision because of age, disability, or illness including mental illness. This might include:

- help with mobility or transport,
- help with dressing, feeding, bathing,
- continence care,
- medication management.

Please be as **specific as possible** about how many hours of care you provide each day. If you don't spend time caring on any of the below days, please enter a zero (**0**) in the space available.

40. How many hours each day do you provide care? Insert the average hours of care for each day:

☐☐.☐ Monday
☐☐.☐ Tuesday
☐☐.☐ Wednesday
☐☐.☐ Thursday
☐☐.☐ Friday
☐☐.☐ Saturday
☐☐.☐ Sunday

Caring details

41. Do you live with the person you are caring for? ☐ Yes ☐ No

If **yes**, proceed to **question 44**.

If **no**, please state their address:

County Eircode

42. How far away do you live from the person you are caring for?

- ☐ Less than 50 kilometres.
- ☐ 50 to 100 kilometres.
- ☐ 100 to 150 kilometres.
- ☐ More than 150 kilometres.

43. What communication system links your household with the household of the person you are caring for? Please place an **X** in all that apply.

- ☐ Landline phone.
- ☐ Mobile phone.
- ☐ Personal monitored alarm system.
- ☐ Other, please state:

Continued on the next page.

Caring details

44. Does the person you are caring for attend a care centre or other setting, such as a nursing home, rehabilitation centre or day care? ☐ Yes ☐ No

If **no**, please proceed to **question 45**.

Do they stay overnight in this care centre or other setting? ☐ Yes ☐ No

What is the number of nights they stay each week? ☐ nights.

What is the number of days they attend each week? ☐ days.

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

What is the name and address of the care centre or care setting?

Name:

Address:

County Eircode

45. Is the person you are caring for currently in hospital or a nursing home? ☐ Yes ☐ No

If **yes**, please state:

Date they were admitted to the hospital or nursing home: D D M M Y Y Y Y

Note: If the person you are caring for is in hospital or in a nursing home, you must provide a discharge letter before Carer's Benefit can be awarded.

46. Is Domiciliary Care Allowance currently in payment to you or another person if you are caring for a child under 16 years of age? ☐ Yes ☐ No

Note: If Domiciliary Care Allowance is in payment, you will not have to submit a medical report or complete **Part 9** as part of this application.

Part 7 Declaration

I declare that I have advised the person I care for of this application and that the information I have provided in this application is truthful and complete. If any of the information is untrue or misleading, or if I fail to disclose any relevant information, I understand that I will be required to repay any payment I receive and that I may be prosecuted. I undertake to immediately advise the department of any changes in my circumstances, or the circumstances of the person I care for, that may affect my continued entitlement.

I understand that my claim may be reviewed at any time to ensure that both the person I care for and I continue to meet the eligibility criteria.

Signature, **not** capital letters.

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

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

Section 2
Care Needs

Part 8 Carer's Details

1. PPS number:

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

3. Surname:

4. First names:

5. PPS number of the person you are caring for:

Part 9 Care Needs

Physical or Personal Care

6. Does the person you care for need help or assistance to eat or drink? For example, they may need supervision while eating or need to be spoon or tube fed. ☐ Yes ☐ No

If **yes**, please tell us about the help or assistance to eat or drink that they need. Please include how often you have to provide this help:

7. Does the person you care for have difficulty washing themselves without help? This might include brushing their teeth and washing their hands, face, or body. ☐ Yes ☐ No

If **yes**, please give details of the help and support they need to wash, including:

- the difficulties they experience washing themselves,
- the care you have to provide to them, and
- how often they require this care.

8. Does the person you care for have difficulty dressing themselves? This might include managing buttons and zips, or putting on socks and shoes. ☐ Yes ☐ No

If **yes**, please give details of the help and support they need to dress, including:

- the difficulties they experience dressing themselves,
- the care you have to provide to them, and
- how often they require this care.

9. Does the person you care for need help using the toilet? ☐ Yes ☐ No

If **yes**, please give details of the help they need when using the toilet, including how often you have to provide this support.

10. Does the person you care for have continence problems such as wetting or soiling? ☐ Yes ☐ No

If **yes**, please give details of the help and support they need, including:

- how often they have problems with wetting or soiling, and
- the care you have to provide to them.

11. Does the person you care for have hearing or vision difficulties? ☐ Yes ☐ No

If **yes**, please give details of their hearing or vision difficulties, including:

- the care they need, and
- any specialist equipment or assistive technologies used.

12. Does the person you care for have difficulty walking or moving around? ☐ Yes ☐ No

If **yes**, which of the following describe their difficulties? Please place an **X** in all that apply:

☐ Needs help moving to or from a bed or chair.

☐ Needs help moving to or from a toilet, bath or shower.

☐ Needs a walking stick or mobility aid to get around the house.

☐ Needs help climbing up and down stairs.

☐ None of the above.

Please tell us more about their difficulties walking or moving around, including:

- the care they need,
- how often you have to provide this care, and
- any specialist equipment or mobility aids used.

Care needs

13. Does the person you care for often require care during the night? For example, they may need supervision and help with toileting, medication, or pain relief.

☐ Yes ☐ No

If **yes**, please give details of the care they need at night, including how often you have to provide this care.

Learning, Behaviour, Memory or Mental Health

14. Does the person you care for experience challenges communicating with other people? This might include speech and language difficulties or difficulty expressing their needs.

☐ Yes ☐ No

If **yes**, please give details of the help and support they need, including:

- the challenges they experience communicating,
- the care you have to provide to them, and
- how often you provide this care.

15. Does the person you care for have a learning or behavioural disability that affects them day-to-day?

☐ Yes ☐ No

If **yes**, please give details of their disability, including:

- how it affects their understanding of day-to-day activities,
- how it affects their ability to complete day-to-day activities, and
- the care you have to provide to support them.

16. Does the person you care for have a mental health condition? ☐ Yes ☐ No

If **yes**, please give details of their condition, including:

- how it impacts them, and
- the care you provide to support them.

17. Does the person you care for experience memory loss or have dementia? ☐ Yes ☐ No

If **yes**, please give details of how memory loss or dememtia impacts them and the care you have to provide to support them.

18. Does the person you care for experience loss of consciousness? For example, fainting episodes, blackouts, or seizures. ☐ Yes ☐ No

If **yes**, please give details of the difficulties they experience with loss of consciousness, including:

- how it impacts them,
- how often they've experienced loss of consciousness in the last 12 months, and
- the care you provide for them.

Care needs

Additional supervision and care needs might include:

- the use of specialist equipment,
- techniques to help with breathing,
- special feeding arrangements,
- dialysis,
- dressing wounds,
- stoma care requirements,
- special transport arrangements, and
- preparation and administration of medication.

19. Does the person you care for have any additional care needs that have not already been mentioned in this application? ☐ Yes ☐ No

If **yes**, please give details of their additional care needs, including:

- how often they occur,
- any care you will provide to help, and
- any specialist equipment or arrangements required.

20. Is there anything else you would like to tell us about the condition or care needs of the person you care for? ☐ Yes ☐ No

If **yes**, please tell us about any other concerns you have regarding their condition or care needs.

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments and benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at **www.gov.ie/dsp/privacystatement** or in hard copy.

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Section 3
Medical Report for
Carer's Benefit

Part 1 Carer's details

1. PPS number:

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

3. Surname:

4. First names:

5. Date of birth:

D D M M Y Y Y Y

Part 2 Medical Report

Dear Doctor,

To enable us to accurately assess the level of care and attention your patient requires, please complete the medical report below. The medical information provided will be reviewed by our medical assessors and will be treated in strictest confidence. Although a confidential report, both medical and non-medical staff will need to deal with this report in order to process the claim.

You will be paid a special fee for fully completing and returning this report. To ensure payment, please enter your DSP Panel Number in the box provided.

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

Medical Report begins on the next page.

Medical Report

6. Patient's details:

Surname:

First names:

Address:

County

Eircode

Date of birth:

D D M M Y Y Y Y

PPS number:

Your patient since:

D D M M Y Y Y Y

Main diagnosis or diagnoses:

Diagnosis relevant to application	Date (MM/YY) of diagnosis, if relevant	ICD10 code

Current medications:

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

7. Is your patient terminally ill? ☐ Yes ☐ No

8. Please give details of the following:

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

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

Other information, if relevant:

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

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

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

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

Mental Health: ☐ Normal ☐ Impaired

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

Seizures: ☐ Stable ☐ Unstable

If **unstable**, state frequency:

Does the patient have epilepsy? ☐ Yes ☐ No

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

Mobility: ☐ Dependent ☐ Independent or age-appropriate

Please describe the care that is required, for example, needs assistance, walking aids, immobility, or wheelchair dependency:

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

Area	Ability level			
	Normal	**Glasses or hearing aids**	**Impaired**	**If impaired, please describe known care needs**
Vision				
Hearing				
Speech				

Area	Ability level			
	Independent	**Dependent**	**Do not know**	**If dependent, please describe known care needs**
Continence or toileting				
Bathing or showering				
Feeding				
Dressing				

Specific conditions:

How long do you expect these care needs to continue?

☐ Less than 12 months. ☐ 12 to 24 months. ☐ Unknown. ☐ Indefinitely.

Current clinical findings, care needs or concerns:

Part 3 Doctor's declaration

11. GP's name:

12. DSP panel number:

13. IMC number:

14. Address:

County

Eircode

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

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

Doctor's official stamp

All information given in this section is covered by the Data Protection Act and the Official Secrets Act.

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Section 4
Employer Declaration for Carer's Benefit

Part 1 Employer details

Employer name:

Employer address:

County

Eircode

Part 2 Employee details

1. Please state your **employee's** details:

Employee's first name:

Employee's surname:

PPS number:

2. What are your employee's current weekly working hours? . hours a week

3. Please answer either a) or b) below:

a) If your employee intends to **leave** work, please state:

Date from: 2 0

Date to: 2 0

D D M M Y Y Y Y

b) If your employee is reducing their hours, please state:

They will work: . hours a week

From: 2 0

To: 2 0

D D M M Y Y Y Y

Continued on the next page.

After the reduction in your employee's hours, please confirm details of the **new reduced income**:

Gross earnings: € , . a week

Minus statutory deductions:

Income tax: € , . a week

Pay Related Social Insurance (PRSI): € , . a week

Pension (AVC, PRSA, ASC): € , . a week

Universal Social Charge (USC): € , . a week

Trade Union: € , . a week

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

Signature by or for employer, **not** capital letters.

Position in the company

Employer's registered number

Official Stamp

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Section 5
Education Declaration for Carer's Benefit

Part 1 Education or Course Provider details

This form must be completed by your Education or Course provider.

Education or course provider's name:

Education or course provider's address:

County

Eircode

Student's PPS number:

Student's first name:

Student's surname:

Name of course:

Course start date: D D M M 2 0 Y Y Y Y

Course end date: D D M M 2 0 Y Y Y Y

Please provide the weekly hours required for this course inclusive of attending lectures, practicals, seminars, study, coursework and assignments:

Total weekly hours: .

Education or Course Provider details

Date: D D M M 2 0 Y Y

Signature by or for education or course provider, **not** capital letters.

Position.

Official Stamp

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