Social Welfare Services
CARB 1
Data Classification Confidential

Application form for Carer's Benefit

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.
- 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 **Part 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 Benefit as soon as you start caring for someone. You could lose payment if you don't.

How to fill in first page of 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

Application form for
Carer's Benefit

Social Welfare Services
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Part 1 — Your own 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.

Date: D D M M 2 0 Y Y

Signature (**not** block letters)

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. If you have ever claimed Carer's Benefit or Carer's Allowance, please state:

Your claim or reference number:

Your address when you claimed:

15. If anybody else has applied for Carers Benefit/Allowance or are they getting Carers Benefit/Allowance for the person who you are now caring for, please state:

Their surname:

Their first name(s):

Their PPS No.:

16. If you are getting any payment from this Department or the Health Service Executive (for example, Supplementary Welfare Allowance), please state:

Name of payment:

Your claim or reference number:

Amount: € , . a week

17. Please give details of all of your most recent or current employer:

Employer's name:

Employer's address:

Employer's telephone number:

MOBILE

LANDLINE

Part 2 continued — Your work and claim details

18. When did you start working with your current employer (if relevant)? D D M M Y Y Y Y

19. When did you start caring? D D M M Y Y Y Y

20. Do you have a second employer? ☐ Yes ☐ No

If you have resigned from employment, please enclose your P45.

21. If you are currently employed, when do you intend to take leave for caring purposes?

D D M M Y Y Y Y

22. Are you self-employed? ☐ Yes ☐ No

Part 3 — 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:

23. Do you have a Social Services Card? ☐ Yes ☐ No

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 4 — To be completed by your most recent or current employer

Important note: Your current or last employer must complete this part even if you have left work. A P60 or P45 is not enough.

24. Please state, your employee's:

Surname:

First name(s):

PPS No.:

25. Is this employment:

☐ Part-time

☐ Full-time

26.(a) Please state number of hours worked by employee before commencing carer's leave:

Hours: ☐☐ a week

or

Hours: ☐☐ a fortnight

26.(b) If the employee is awarded carer's leave, please state:

Date they intend to leave work:

From: ☐☐ ☐☐ ☐☐☐☐

To: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

Date they intend to reduce their hours:

From: ☐☐ ☐☐ ☐☐☐☐

To: ☐☐ ☐☐ ☐☐☐☐

D D M M Y Y Y Y

If your employee is reducing their hours, please state:

Hours reduced:

From: ☐☐ a week **or** ☐☐ a fortnight

To: ☐☐ a week **or** ☐☐ a fortnight

New Gross Earnings (excluding superannuation): € ☐☐☐,☐☐☐.☐☐ a week

Tax deduction: € ☐☐☐,☐☐☐.☐☐ a week

Employee's PRSI deducted: € ☐☐☐,☐☐☐.☐☐ a week

Public Service Pension Levy: € ☐☐☐,☐☐☐.☐☐ a week

Universal Social Charge: € ☐☐☐,☐☐☐.☐☐ a week

Employer's: Please note this section continues on the next page.

Part 4 continued

To be completed by your most recent or current employer

27. Please state type of leave your employee intends to take or has taken:

☐ Carer's leave

☐ Other (please specify below)

28. Please answer (a) or (b) below:

(a) Please give details of employee's PRSI record for the 12 month period immediately before their carer's leave starts:

Period of employment: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Number of weeks:

PRSI class:

or

(b) Please give details of employee's PRSI record immediately before they left your employment:

Period of employment: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Number of weeks:

PRSI class:

29. If less than 52 weeks applies, state the number of weeks the employee worked at 16 hours or more in the previous 26 weeks (please note the relevant 26 week period will be the last 26 weeks actually worked by the employee):

Signed by or for employer

Signature (**not** block letters)

Position in company or organisation

Employer's official stamp

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

Employer's registered number:

Employer's telephone number: MOBILE

LANDLINE

Employer's email address:

Warning: If you make a false or misleading statement to obtain Carer's Benefit for another person, you may face a fine, a prison sentence or both.

Part 5 Details of your qualified child(ren)

30. 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 spouses's, civil partner's or cohabitant's details

31. Their PPS No.:

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

33. Their surname:

34. Their first name(s):

35. Their birth surname:

36. Their mother's birth surname:

37. Their date of birth:

D D M M Y Y Y Y

38. 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.

39. If they are getting any payment from this Department or the Health Service Executive (for example, Supplementary Welfare Allowance), please state:

Name of payment:

Their claim or reference number:

Amount: € , . a week

Please attach the most recent payslip or letter from the Social Security Agency confirming the above amount.

40. If they are getting any other pension or allowance, please state:

Who pays this pension:

Their claim or reference number:

Amount: € , . a week

Please attach the most recent payslip or letter from the people who pay them confirming the above amount.

41. If they are paying maintenance, please state:

Amount: € , . a week

42. If they are receiving maintenance, please state:

Amount: € , . a week

Part 8 Details of person you are caring for

43. Their PPS No.:

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

45. Their surname:

46. Their first name(s):

47. Their birth surname:

48. Their date of birth:

D D M M Y Y Y Y

49. Their address:

50. Their mother's birth surname:

51. What is your relationship to the person you are caring for?

52 (a). Date you started caring for this person:

D D M M Y Y Y Y

(b). Has anyone paid you to look after this person since this date?

☐ Yes ☐ No

53. Are they getting Domiciliary Care Allowance?

☐ Yes ☐ No

54. If 'No', have you or anyone applied for Domiciliary Care Allowance for them?

☐ Yes ☐ No

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

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

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

☐ Yes ☐ No

57. Do they stay overnight in any of these centres?

☐ 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.

Details of person you are caring for

58. 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 hours they attend: ☐☐ a day

Number of days they attend: ☐ a week

Please attach letter of confirmation from day care centre.

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

☐ Yes ☐ No

If 'No', please state:

Number of hours you will be providing care while on Carer's Leave: ☐☐ a day

Number of days you will be providing care while on Carer's Leave: ☐ 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

Please answer the above question fully if the person you are caring for does not live with you.

Part 9 Checklist

Has your employer completed Part 4?
Have you enclosed the following?

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

— **A statement from accountant if you are 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 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.

Original certificates only.

If your form is not fully complete or the documents required are not enclosed there will be a delay in deciding your claim for Carer's Benefit.

Please remember to sign the declaration in Part 1.

Send the completed application form and other documents to:

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

LoCall: 1890 92 77 70 (from the Republic of Ireland only)

Telephone: + 353 43 3340000 (from Northern Ireland or overseas)

Important: You could lose payment if you do not apply as soon as you start caring.

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.

60K 03-11 Edition: March 2011

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.

Social Welfare Services
Med Rpt CARB1

Medical Report for Carer's Benefit

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 Benefit.

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 Benefit 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 Benefit 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 Benefit 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 Benefit 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 BENEFIT 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:

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)

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

Doctor's official stamp

For official use only

(i) **Eligible for Carer's Benefit:** ☐

(ii) **Review:**

(iii) **DNRA:** ☐

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

Give reasons:

Signed _____ **Medical Assessor**

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

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