Application form for
Carer's Allowance

How to complete application form for Carer's Allowance.

- 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. If a question does not apply to you, please leave the answer area blank.
- You need a Personal Public Service Number (PPS No.) before you apply.

If you do not have a spouse or partner fill in **Parts 1, 2, 3, 4, 5 and 8** as they apply to you. The person you are caring for should sign **Part 10** confirming that they require care. You should then get the doctor to complete the medical report. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

If you have a spouse or partner please fill in **Part 1, 2, 3, 4, 5, 6, 7 and 8** as they apply to you. The person you are caring for should sign **Part 10** confirming that they require care. You should then get the doctor to complete the medical report. When the form is completed, read **Part 9** and sign declaration in **Part 1**.

If you need any help to complete this form, please contact your local Social Welfare Office or Citizens Information Centre.

For more information, log on to **www.welfare.ie**.

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

How to fill 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: 01 7043000
LANDLINE
086 1234567
MOBILE

11. Your email address: MMURPHY@WELFARE.IE

SAMPLE

Social Welfare Services
CR1

Application form for
Carer's Allowance

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:** LANDLINE / MOBILE
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 ☐ Widowed ☐ Remarried ☐ Divorced
☐ Married ☐ Cohabiting ☐ Separated

13. If you are married 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 Allowance or you are getting Carer's Allowance, please state:

Your claim or reference number:

Your address when you claimed:

15. If anybody else has applied for Carer's Allowance or are they getting Carer's Allowance for the person who you are now caring for, please state:

Their name:

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. If you are separated and paying maintenance, please state:

Amount: € , . a week

Please attach a copy of Maintenance Order or Separation Agreement

18. If you are separated and receiving maintenance, please state:

Amount: € , . a week

Please attach a copy of Maintenance Order or Separation Agreement

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

Name of country:

Your claim or reference number:

Amount: € , . a week

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

Your work and claim details

20. If you are getting any other pension or allowance, please state:

Who pays this pension:

Your claim or reference number:

Amount: € , .

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

21. If your spouse or partner is getting paid for you on their pension or allowance, please state:

Their PPS No.:

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

☐ Yes ☐ No

If 'Yes', please attach a letter from college giving details of your course and the hours you attend.

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

Employer's name:

Employer's address:

Gross weekly earnings: € , . a week

Please attach your most recent payslip.

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

Type of work you do:

Gross weekly earnings: € , . a week

Date you started self-employment:

D D M M Y Y Y Y

Please attach a statement of accounts from your accountant.

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

☐ Yes ☐ No

If 'Yes', please attach your P45, if you have already stopped working.

Your work and claim details

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

(a) remain at work for up to 15 hours a week: ☐ Yes* ☐ No

or

(b) return to work for up to 15 hours a week: ☐ Yes* ☐ No

* Please get a statement from your employer and attach it to this application. The statement should show the number of hours worked or to be worked each week and the wages earned. If you are reducing your working hours to 15, the statement should include the date on which this takes place. If you are self-employed, please attach a note showing type of work, proposed number of hours and income.

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

Financial Institution 1

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 2

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 3

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 4

Name of financial institution:

Account number:

Current balance: € , .

Please attach a statement for **each** account, showing balance for the last **three** months.

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

Their value: € , .

Please attach a statement to show current market value.

Your work and claim details

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

Size of farm or land: ☐☐☐ acres

Net yearly income or rent from farm or land: € ☐☐,☐☐☐.☐☐

'Net yearly income' is money you have made from the farm **after** deducting operating expenses. Please attach a copy of Farm Accounts

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

Type of property:

Address of property:

'Property' would be an apartment, business property, another house or land other than that mentioned at question 29.

Current market value: € ☐,☐☐☐,☐☐☐.☐☐

Rent from this property: € ☐,☐☐☐.☐☐ a week

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

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

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

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

Part 3 Habitual Residence Condition

This section must be completed by all applicants.
Habitual residence is a condition that you must satisfy to qualify for Carer's Allowance.
For more information, log on to **www.welfare.ie**.

35. What country were you born in?

36. What is your nationality?

37. When did you come to live in the Republic of Ireland?

D D M M Y Y Y Y

38. Have you lived in the *common travel area all of your life including the last 2 years?

☐ Yes ☐ No

If 'No', please complete questions 39 to 42.

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

Country 1

Country:

From:

To:

D D M M Y Y Y Y

Why you lived there:

Country 2

Country:

From:

To:

D D M M Y Y Y Y

Why you lived there:

Habitual Residence Condition

Country 3

Country:

From:

To:

D D M M Y Y Y Y

Why you lived there:

Note

The *common travel area is Ireland, Great Britain, the Isle of man and the Channel Islands. You can spend brief periods on short holidays, studying or travelling outside the common travel area and still may be habitually resident here.

If you live in Northern Ireland, Great Britain, the Isle of Man or the Channel Islands, please provide proof of residence. Residency may be verified by production of a passport or identity card and one or more of the following: employment records such as P45, P60, bank statements, details of benefit payments, utility bills, rent or mortgage agreements or receipts for local authority charges.

39.Have you lived at the same address for the last 2 years?

☐ Yes ☐ No

If 'No', please give details of where you lived in the space provided.

Last address:

From:

To:

D D M M Y Y Y Y

Previous address:

From:

To:

D D M M Y Y Y Y

Habitual Residence Condition

40.Have you lived continuously in Ireland since the day you arrived?

☐ Yes ☐ No

41.Does any of your close family, for example, parent, brother, sister or child, live in Ireland?

☐ Yes ☐ No

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

Person 1

Their surname:

Their first name(s):

Their address:

Their date of birth:

D D M M Y Y Y Y

Their relationship to you:

When they came to Ireland:

D D M M Y Y Y Y

Person 2

Their surname:

Their first name(s):

Their address:

Their date of birth:

D D M M Y Y Y Y

Their relationship to you:

When they came to Ireland:

D D M M Y Y Y Y

Habitual Residence Condition

Person 3

Their surname:

Their first name(s):

Their address:

Their date of birth:

D D M M Y Y Y Y

Their relationship to you:

When they came to Ireland:

D D M M Y Y Y Y

Person 4

Their surname:

Their first name(s):

Their address:

Their date of birth:

D D M M Y Y Y Y

Their relationship to you:

When they came to Ireland:

D D M M Y Y Y Y

Part 3 continued — Habitual Residence Condition

42.Have you ever made an application for refugee status?

☐ Yes ☐ No

If 'Yes', please answer both questions (a) and (b) and provide copies of all relevant documentation from the Department of Justice, Equality and Law Reform.

(a) Are you awaiting a decision on an application for refugee status?

☐ Yes ☐ No

(b) Have you been granted refugee status or leave to remain in the State?

☐ Yes ☐ No

If 'Yes', to (b) please provide copies of all relevant documentation from the Department of Justice, Equality and Law Reform.

For official use only

HRC satisfied ☐ HRC not satisfied ☐ HRC1 issued ☐

Part 4 — Your payment details

You can get your payment at your local post office or direct to your current, deposit or savings account in a financial institution. Please complete one option below.

Post Office

Post Office address:

Financial Institution

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

Name of financial institution:

Sort code:

Account number:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Part 5 Details of your qualified child(ren)

43. 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.:

Surname:

First name(s):

PPS No.:

Surname:

First name(s):

PPS No.:

Part 6 Your spouse's or partner's details

44. Their PPS No.:

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

46. Their surname:

47. Their first name(s):

48. Their birth surname:

49. Their mother's birth surname:

50. Their date of birth:

D D M M Y Y Y Y

51. Their address:

Only answer this question if you are married and do not live together.

Part 7 Your spouse's or partner's work and claim details

Please complete this section for your spouse or partner.

52. If they are separated and paying maintenance, please state:

Amount: € , . a week

53. If they are separated and receiving maintenance, please state:

Amount: € , . a week

54. If they are getting a social security payment from another country, please state:

Name of country:

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.

55. 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.

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

Employer's name:

Employer's address:

Gross weekly earnings: € , . a week

Please attach their most recent payslip

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

Type of work they do:

Gross weekly earnings: € , . a week

Date they started self-employment:

D D M M Y Y Y Y

Please attach a statement of accounts from their accountant

Part 7 Your spouse's or partner's work and claim details

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

Financial Institution 1

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 2

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 3

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 4

Name of financial institution:

Account number:

Current balance: € , .

Please attach a statement for **each** account, showing balance for the last **three** months.

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

Their value: € , .

Please attach a statement to show current market value.

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

Size of farm or land: acres

Net yearly income or rent from farm or land: € , .

'Net yearly income' is money they have made from the farm **after** deducting operating expenses. Please attach a copy of Farm Accounts

Part 7 Your spouse's or partner's work and claim details

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

Type of property:

Address of property:

'Property' would be an apartment, business property, another house or land other than that mentioned at question 60.

Current market value: € , , .

Rent from this property: € , . a week

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

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

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

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

Part 8 Details of person you are caring for

66. Their PPS No.:

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

68. Their surname:

69. Their first name(s):

70. Their birth surname:

71. Their mother's birth surname:

72. Their date of birth:

D D M M Y Y Y Y

73. Their address:

74. Has anyone paid you to look after this person since this date?

☐ Yes ☐ No

75. Are they getting Domiciliary Care Allowance?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

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

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

☐ Yes ☐ No

79. 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.

Part 8 Details of person you are caring for

80. 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.

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

Yes No

If 'No', please state:

Number of hours you provide care: a day

Number of days you provide care: a week

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

Yes No

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

The Distance between the households: Kilometres

Is there a direct phoneline between the households?

Yes No

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

Details of daily duties you perform looking after this person:

Note

If you are caring for more than 1 person, please fill in CR2 and send it to Carer's Allowance Section, Social Welfare Services, Ballinalee Road, Longford. You can get form CR2 online at www.welfare.ie or from your local Social Welfare Office. If you are caring for more than 2 people please complete an CR2 form for each additional person as you may get Respite Care Grant for them.

Part 9 Checklist

Have you enclosed the following?

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

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

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

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

— **A statement from accountant if you or your spouse is self-employed**

If born or married outside the Republic of Ireland:

— **Your birth certificate**

— **Your marriage certificate**

— **Your spouse's or partner's birth certificate** (if applying for an increase for them)

— **Your child(ren)'s birth certificate(s)** (if applying for an increase for them)
Note: No birth certificate is needed if you are already getting Child Benefit.

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 Allowance.

Please remember to sign the declaration in Part 1.

Send the completed application form and other documents to:

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

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

Telephone: Dublin (01) 704 3000

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

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 and Family Affairs, 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.

30K 10-09 Edition: October 2009

Note to carer

Important

You do not need to send a medical report at this stage for a child for whom Domiciliary Care Allowance is being paid by this Department.

The following medical forms are in two parts. **Have Section A completed and signed by the person being cared for**.

You must then pass the entire medical form to the doctor of the person being cared for. The doctor may return the form to you in a sealed envelope to keep their patient's medical details confidential.

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

Medical Report for
Carer's Allowance

Part 10 Medical Report

Section A

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

Surname:

First name:

PPS No.:

Declaration by person receiving full-time care and attention

Section A

Authorisation

I need **full-time care** and **attention** and the person named in Part 1 is providing full-time care and attention to me. I will tell the Department of Social and Family Affairs if this changes.

I permit my doctor to provide you, the Department of Social and Family Affairs, with medical information that you may need for this application for Carer's Allowance.

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

Signature (**not** block letters)

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

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

Signature (**not** block letters)

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

Note

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

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

Section B

Section B

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess if they qualify for care under the Carer's Allowance scheme, please complete the medical report across. The medical information provided will be reviewed by one of our Medical Assessors, who will treat it in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

You can get a special fee for fully completing and returning this report. To ensure payment please enter your DSFA panel number in the box provided.

For reasons of medical confidentiality, you may wish the medical evidence for your patient to be passed to the Department's Chief Medical Adviser, without potential inspection by other people. If you have any questions on this matter, please contact the Department at the telephone number given below.

If you have any queries, please contact the **Carer's Allowance Section** at LoCall: 1890 92 77 70.

Note:

The carer should already have filled Parts 1 and 8 of the application form. The person(s) being cared for must have completed Section A of this medical report.

THE COMPLETED MEDICAL REPORT FORM SHOULD BE RETURNED BY THE DOCTOR TO THE CARER WHO WILL SEND IT, ALONG WITH HIS/HER APPLICATION FORM, TO THE CARER'S ALLOWANCE SECTION.

Section B

1. Patient details

Surname:

First name:

Address:

Date of birth:

D D M M Y Y Y Y

PPS No.:

Mobile telephone No.:

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

2. Your patient since:

D D M M Y Y Y Y

3. Diagnosis(es) (use BLOCK CAPITALS):

4. ICD10 Code(s):

5. Date condition started:

D D M M Y Y Y Y

6. How long do you expect this condition to continue?

- ☐ less than 3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ 12-24 months
- ☐ indefinitely

Medical Report

7. Please give:

Medical history

Surgical/Obstetrical history

Hospital admissions

Date of discharge: D D M M Y Y Y Y

Result of relevant investigations

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

Attending a specialist

On medication

Other treatment

9. Pregnant: ☐ Yes ☐ No

If 'Yes', give EDD: D D M M Y Y Y Y

Please attach any relevant reports/results of investigations.

Additional Information:

Medical Report

Ability/Disability Profile:

10. Indicate the degree to which your patient's condition has affected their ability in ALL of the following areas.

	Normal	Mild	Moderate	Severe	Profound
Mental Health/Behaviour →	☐	☐	☐	☐	☐
Learning/Intelligence →	☐	☐	☐	☐	☐
Consciousness/Seizures →	☐	☐	☐	☐	☐
Balance/Co-ordination →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Manual Dexterity →	☐	☐	☐	☐	☐
Lifting/Carrying →	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting →	☐	☐	☐	☐	☐
Sitting/Rising →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing Stairs/Ladders →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

11. A Medical Assessment by one of the Department's Medical Assessors may be required to determine eligibility.

Is your patient fit to attend a medical assessment? ☐ Yes ☐ No

If 'No', give details here:

Doctor's name:

DSFA panel number:

IMC number:

Address:

Doctor's Signature (**not** block letters)

Doctor's official stamp

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

For Official use Only

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

(ii) **Review:** ☐

(iii) **DNRA:** ☐

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

Give reasons:

Signed _____ **Medical Assessor**

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

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