Social Welfare Services Office
CARB1

Application form for Carer's Benefit

- Please read information booklet SW 49 before completing this application form.
- Please use BLOCK LETTERS and place a tick (✓) in the appropriate boxes.
- Please answer all questions fully as incomplete information may delay processing your application.
- Please make sure that each person receiving care from you signs Part 9 of this form and that each of their doctors completes the medical report.
- You as the carer must sign Part 8.
- You could lose payment if you do not apply as soon as you start caring.

If you need any help completing this form, please contact your local Social Welfare Office or Carer's Benefit Section.
Telephone: Longford (043) 40086 or 40087 or Dublin (01) 704 3000 ext. 48786 or 48787

Part 1 Your own details

Please state: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____ (Please specify)

1. **What is your full name?** Last name / First name(s)
2. **What is your birth surname (your surname before you were married), if different?**
3. **Where do you live?** Address
4. **What is your telephone number, if any?** Landline no. / Mobile no.
5. **What is your e-mail address, if any?**
6. **What is your date of birth?** ☐☐ Day ☐☐ Month ☐☐☐☐ Year
7. **What is your PPS No. (Personal Public Service Number)?** Figures ☐☐☐☐☐☐☐ Letter(s) ☐☐
8. **Are you ...?** 'Cohabiting' means you live with a man or woman as husband or wife and you are not married to them. ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Divorced ☐ Cohabiting
9. **Have you ever claimed Carer's Benefit or Allowance before?** ☐ Yes ☐ No
10. **Are you getting any payment from this Department?** ☐ Yes ☐ No
    If 'Yes', state name of payment:

Part 2 Your payment details

You can get Carer's Benefit paid weekly direct to your account in a financial institution.

This account must be a current or deposit savings account (not a mortgage account).

Direct payment has a number of advantages:
- **your payment is lodged directly to your account on the day of payment,**
- **your payment is available at a time and place that suits you, and**
- **you are less likely to deal with delays and queuing.**

Dealings between you and your financial institution remain confidential. The Department does not have access to your bank or building society account.

Direct payment to your account in a financial institution

11. If you want to get your Carer's Benefit by direct payment, please give details here:

Name of financial institution:

Address:

Name on the account:

The account must be in your name or jointly held by you.

Type of account:

If with First Active PLC you must use a deposit account.

Bank sort code (you can get this from your branch):

Account number (8 digits):

If you do not have an account in a financial institution, please contact us to discuss other arrangements.

Part 3 Your employment details

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

Employer's name
Address
Telephone number:

Please complete either question 13 or 14.

13. When did you start working with your current employer (if relevant)? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

14. When did you start caring? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

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

15. If you are currently employed, when do you intend to take leave for caring purposes? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

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.

16. Please state your employee's name:

17. What is your employee's PPS No.?

Figures	Letter(s)
☐☐☐☐☐☐☐	☐☐

18. Please state number of hours worked by employee: ☐☐☐ Weekly ☐☐☐ Fortnightly

19. Is this employment part-time or full-time? ☐ Part-time ☐ Full-time

20. If the employee is still working for you please give dates they intend to leave work for caring purposes.

_____

Please state type of leave ☐ carer's leave ☐ Other _____

Please specify

To be completed by your most recent or current employer

Answer a) or b) below.

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

or

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

Period of employment						Number of weeks	PRSI Class
From			To				
Day	Month	Year	Day	Month	Year		

22. 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 Registered Number

E-mail address

Telephone number
Code Number

Employer's Official Stamp

Date

Part 5 Your spouse's or partner's details

Please state: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____ Please specify

23. What is your spouse's or partner's full name?

Last name

First name(s)

24. What is their birth surname (their surname before they were married), if different?

25. Where do they live?

Address

26. What is their date of birth? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

27. What is their PPS No.?

Figures							Letter(s)	

28. Is your spouse or partner getting any payment from this Department or the Health Service Executive? ☐ Yes ☐ No

If 'Yes', please state:

Name of payment:

Claim or reference Number:

29. Are they in employment? ☐ Yes ☐ No

30. Are they self-employed? ☐ Yes ☐ No

31. Are they getting an occupational pension? ☐ Yes ☐ No

If 'Yes', please state:

Name of person or company that pays pension:

Address:

Part 6 Qualified child details

32. Do you have any children under age 18 or between 18 and 22 in full-time education? ☐ Yes ☐ No

If 'Yes', please give details here of each child you are maintaining, starting with the eldest child, indicating whether or not they live with you.

Attach a letter from the school or college for any child aged between 18 and 22 to confirm that they are in full-time education.

Child's full name	Date of birth			PPS No.	Relationship to you	Is this child living with you?
	Day	Month	Year			

Note:
A qualified child need not be your own child. If you maintain a child and get Child Benefit for them, you may apply for a Qualified Child Increase for them.

33. Does each child live with you? ☐ Yes ☐ No

Qualified children who live in rented accommodation while at college are regarded as living with you.

If 'No', please state:

Name of the person(s) with whom the child(ren) live(s):

Address:

Amount of maintenance paid by you, if any: € a week or month*

*delete as appropriate

Part 7 Details of person(s) you are caring for

	Person 1	Person 2 (if applicable)
34. What is their full name?	Last name First name(s)	Last name First name(s)
35. What is their birth surname (their surname before they married), if different?		
36. Where do they live?	Address	Address
37. What is their date of birth?	Day Month Year	Day Month Year
38. What is their PPS No.?	Figures Letter(s)	Figures Letter(s)
39. What type of payment are they getting, if any?		

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

40. What is their claim or reference number?				
41. What country pays them, if any?				
42. Is Domiciliary Care Allowance being paid for them? If so, please supply evidence of payment from the Health Service Executive.	☐ Yes	☐ No	☐ Yes	☐ No
If not, has anyone applied for Domiciliary Care Allowance for them?	☐ Yes	☐ No	☐ Yes	☐ No

Details of person(s) you are caring for

	Person 1	Person 2 (if applicable)
43. Is the person(s) named at Question 34 attending a day care or rehabilitative centre by day? 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.	☐ Yes ☐ No	☐ Yes ☐ No
If 'Yes', please state:		
Name of centre:		
Address:		
Telephone number of centre:	Code Number	Code Number
Number of days they attend:	days a week	days a week
Number of hours:	hours a day	hours a day
Please attach letter of confirmation from day care centre.		
44. Does each person you are caring for live with you?	☐ Yes ☐ No	☐ Yes ☐ No
If 'No', please state:		
Distance between households:		
If there is a direct phone link?	☐ Yes ☐ No	☐ Yes ☐ No
Is there any other type of direct link (if there is no phone)?	☐ Yes ☐ No	☐ Yes ☐ No
Details of direct link:		

Note

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

Part 8 Declaration by you – the carer

I wish to apply for Carer's Benefit. All the information I have given is true.

I understand that a Social Welfare Inspector can investigate and review my claim to Carer's Benefit at any time. I have given full details of my means and I will tell the Department of Social and Family Affairs within 7 days of any change in my means.

To the best of my knowledge, the person(s) named in Part 7 require(s) full-time care and attention. I am the person providing full-time care and attention and I will tell the Department immediately if there is any change in this arrangement.

Signed	Date

(**not** block letters)

If you (person providing care) cannot sign, make your mark and have it witnessed. The witness cannot be the person being cared for or a member of your household.

Signed	Date

(**not** block letters)

Address of witness

Warning: If you make a false statement or withhold information, you may face a fine, a prison sentence or both.

Send the completed application form to:

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

Telephone: Longford (043) 45211 ext. 48786 or 48787
Dublin (01) 704 3000 ext. 48786 or 48787

If you have any difficulty filling in this form, please phone us in Carer's Benefit Section at the telephone numbers listed above or call to your local Social Welfare Office.

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 bodies in accordance with law. We are responsible for it under the Data Protection Act and Freedom of Information Act.

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

Note to carer

Important

You do not need to send a medical report at this stage for a person for whom Domiciliary Care Allowance is being paid by the Health Service Executive.

The following medical forms are in two parts. **Have Part A completed by the person(s) being cared for**. If the person being cared for cannot complete this form, you should fill it in for them and have it signed by a witness.

You must then pass the entire medical form to the doctor of the person being cared for. **The doctor must complete Part B, questions 1 -7**. 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 (person 1)

Part A (to be completed by the person being cared for)

Authorisation

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 Benefit.

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

Part A - Person 1

Your signature or mark	Date

(**not** block letters)

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 of witness	Date

(**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 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.

Medical report (person 1)

Part 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 overleaf. 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 completing and returning this report. To ensure payment, please enter your 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.

The format of this medical report has been agreed between the IMO and this Department. It is standard for all sickness schemes. However, Carer's Benefit differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with a disability.

If you feel that a bare outline of the disability does not adequately address the need for care, please feel free to add any additional observations on the caring situation at Question 6. You may also attach copies of any reports or other documents that you feel demonstrate the need for full-time care.

If you have any queries, please contact the **Carer's Benefit Section** directly at **(043) 45211, ext. 48786 or 48787.**

Note:

The carer should already have filled in Part 1 Question 1 and Parts 6 and 8 of the application form. The person(s) being cared for must have completed Part A of this medical report section.

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

Part B - Person 1

1. **Patient's full name and address:**

Name

Address

Date of birth: Day Month Year

Your patient since: Day Month Year

2. **Diagnosis** (use BLOCK LETTERS):

3. **Date incapacity started:** Day Month Year

4. **How long do you expect this incapacity to continue?**

☐ 0-3 months ☐ 3-6 months ☐ 6-9 months

☐ 9-12 months ☐ 12-15 months ☐ indefinitely

5. **If the answer to any of the questions listed below is Yes (Y), please give details in boxes provided.**

- Hospital admissions: ☐ Y/N
- Date of most recent hospital admission: Date of discharge:
- Attending a specialist: ☐ Y/N
- On medication: ☐ Y/N
- Other treatment: ☐ Y/N
- Pregnant: ☐ Y/N
- If 'Y', give EDD: Day Month Year

6. **If you have any additional information in this case, give details here:**

Part 2 - Person 1

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

	Normal	Mild	Moderate	Severe	Profound
Mental health →	☐	☐	☐	☐	☐
Learning →	☐	☐	☐	☐	☐
Consciousness →	☐	☐	☐	☐	☐
Balance →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Lifting or carrying →	☐	☐	☐	☐	☐
Manual dexterity →	☐	☐	☐	☐	☐
Bending, kneeling or squatting →	☐	☐	☐	☐	☐
Sitting →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing stairs →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

A medical exam by one of our Medical Assessors may be required to determine eligibility under the Carer's Benefit scheme.

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

If 'No', give details here:

Your signature:

(**not** block letters)

Date:

DSFA Panel Number:

Address:

Doctor's Official Stamp

Medical report (person 2)

Part A (to be completed by the person being cared for)

Authorisation

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 Benefit.

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

Part A - Person 2

Your signature or mark	Date

(**not** block letters)

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 of witness	Date

(**not** block letters)

Note

In signing the authorisation above, you allow your doctor to issue to us the medical information that 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.

Medical report (person 2)

Part 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 overleaf. 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 completing and returning this report. To ensure payment, please enter your 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.

The format of this medical report has been agreed between the IMO and this Department. It is standard for all sickness schemes. However, Carer's Benefit differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with a disability.

If you feel that a bare outline of the disability does not adequately address the need for care, please feel free to add any additional observations on the caring situation at Question 6. You may also attach copies of any reports or other documents that you feel demonstrate the need for full-time care.

If you have any queries, please contact the **Carer's Benefit Section** directly at **(043) 45211, ext. 48786 or 48787.**

Note:

The carer should already have filled in Part 1 Question 1 and Parts 6 and 8 of the application form. The person(s) being cared for must have completed Part A of this medical report section.

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

Part B - Person 2

1. **Patient's full name and address:**

Name

Address

Date of birth: Day Month Year

Your patient since: Day Month Year

2. **Diagnosis** (use BLOCK LETTERS):

3. **Date incapacity started:** Day Month Year

4. **How long do you expect this incapacity to continue?**

☐ 0-3 months ☐ 3-6 months ☐ 6-9 months

☐ 9-12 months ☐ 12-15 months ☐ indefinitely

5. **If the answer to any of the questions listed below is Yes (Y), please give details in boxes provided.**

- Hospital admissions: ☐ Y/N
- Date of most recent hospital admission: Date of discharge:
- Attending a specialist: ☐ Y/N
- On medication: ☐ Y/N
- Other treatment: ☐ Y/N
- Pregnant: ☐ Y/N
- If 'Y', give EDD: Day Month Year

6. **If you have any additional information in this case, give details here:**

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

	Normal	Mild	Moderate	Severe	Profound
Mental health	☐	☐	☐	☐	☐
Learning	☐	☐	☐	☐	☐
Consciousness	☐	☐	☐	☐	☐
Balance	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Lifting or carrying	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Bending, kneeling or squatting	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

A medical exam by one of our Medical Assessors may be required to determine eligibility under the Carer's Benefit scheme.

Is the care recipient fit to attend a medical exam? ☐ Yes ☐ No

If 'No', give details here:

Your signature:

Date:

DSFA Panel Number: (**not** block letters)

Address:

Doctor's Official Stamp

PLEASE SEND OR GIVE THIS COMPLETED MEDICAL REPORT TO THE CARER. THEY WILL SEND IT WITH THEIR APPLICATION FORM FOR CARER'S BENEFIT TO CARER'S BENEFIT SECTION.

For official use only (Person 1)

Suitable for CARB 1 ☐

Review

Examination required ☐

Further medical evidence required ☐

Signed Medical Assessor

Date

For official use only (Person 2)

Suitable for CARB 1 ☐

Review

Examination required ☐

Further medical evidence required ☐

Signed Medical Assessor

Date

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 bodies in accordance with law. We are responsible for it under the Data Protection Act and Freedom of Information Act.

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

4K 08-06

Edition: August 2006