SOCIAL WELFARE SERVICES OFFICE
RCG 1 (a)

Application form for Respite Care Grant for additional person(s)

Do I need to complete this form?

You should only complete this form if you have completed a Respite Care Grant application form (RCG 1) and are claiming Respite Care Grant for caring for more than two people.

- Please complete this form for each additional person you are caring for and attach it to the application form RCG 1.
- Please use BLOCK LETTERS and place a tick (✔) in the appropriate boxes.
- Please answer **all** questions.
- You as the carer must sign the Declaration in Part 3.
- The person you are caring for must sign the Authorisation in Part 4, Page 4.
- The doctor of the person(s) receiving care from you must sign Part 4, Page 7 of this form.
- If you need help to fill in this form, please contact your local Social Welfare Office or Respite Care Grant Section at (01) 673 2222.

Note to carer

You do **not** need to apply for the Respite Care Grant if:

- you, or anyone else, is getting Carer's Allowance, Carer's Benefit, Domiciliary Care Allowance or Prescribed Relative Allowance for caring for this person(s)
  or
- if the person receiving care is getting Constant Attendance Allowance.

The Respite Care Grant is paid automatically to anyone getting one of these payments.
One Respite Care Grant only is paid for each person needing full time care and attention.
The Grant is payable only where the 6 month period of care includes the first Thursday in June.

Part 1 Your own details

1. What is your name?

'Birth surname' is your surname before you married

Last name

First name(s)

Birth surname

2. Where do you live?

Address

3. What is your telephone number?

Code Number

4. What is your e-mail address?
Please supply if you are happy for us to contact you by e-mail

5. What is your Personal Public Service Number (PPS No.)**?**
(same as RSI or tax number)

Figures							Letter(s)	

6. How many people are you caring for?

Part 2 Details of person you are caring for

7. What is their full name?

Last name

First name(s)

'Birth surname' is your surname before you married

Birth surname

8. What is their date of birth?

Day Month Year

9. What is their Personal Public Service Number (PPS No.)? (same as RSI or tax number)

Figures Letter(s)

10. Does this person live with you? ☐ Yes ☐ No

If 'No', where do they live?

Address

Is this address a full-time residential care facility? ☐ Yes ☐ No

If 'No', what is the distance between households?

Is there is a direct phone link? ☐ Yes ☐ No

Is there any other type of direct link (if there is no phone)? ☐ Yes ☐ No

Details of direct link:

11. When did you start providing full-time care for this person?

Day Month Year

12. Have you been or are you likely to be providing full-time care and attention for at least 6 months? ☐ Yes ☐ No

Important: The Grant is payable only where the 6 month period of care includes the first Thursday in June. Please see information booklet SW 113 for more information.

Part 2 continued — Details of person you are caring for

13. What type of payment are they getting (if any) from this Department?

Claim/Reference Number

14. Is anyone else getting Carer's Allowance or Carer's Benefit for this person? ☐ Yes ☐ No

15. Is a Domiciliary Care Allowance being paid for this person? ☐ Yes ☐ No

The Respite Care Grant is paid automatically to anyone getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance. One Grant only is paid for each person needing full-time care and attention.

Part 3 — Declaration by you - the carer

Important: Please complete this section fully. If you don't, your application cannot be processed.

I apply for Respite Care Grant. I declare the information I have given is true.

To the best of my belief, the person named in Part 2 requires full-time care and attention. I am the person providing this care and have done so, or will do so, for at least 6 months. The period of care includes the first Thursday in June.

Signed (**not** block letters) Date

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.

Signature of witness (**not** block letters) Date

Address of witness

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

This completed form should be attached to your RCG 1 application form and sent to:

Respite Care Grant Section
Department of Social and Family Affairs
PO Box 10085
Dublin 2
Telephone (01) 673 2222

If you need help to fill in this form or have any queries about the Respite Care Grant, please phone us at the telephone number above
or
contact 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 which you give as confidential. We will only disclose it to other bodies in accordance with law. We are responsible for your information under the Data Protection Act and Freedom of Information Act.

Note to Carer

The following medical report is in two parts.

Have Part A completed by the person being cared for. If the person being cared for cannot complete this form, it should be filled in for them and signed by a witness.

You must then pass the medical report to the doctor of the person being cared for. **The doctor must complete Part B, questions 1-7 inclusive.** As this is quite detailed, the doctor is unlikely to be able to complete the form immediately. You may both agree a suitable time for you to collect it. The doctor may decide to return the form to you in a sealed envelope, for reasons of medical confidentiality.

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

Part A

Authorisation (to be completed by person being cared for)

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 Respite Care Grant.

Signature or mark	Date
(**not** block letters)	

If you cannot sign, have somebody witness the Authorisation and sign below on your behalf. 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 rules of the Respite Care Grant.

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

Part B

Dear Doctor,

Please complete the medical report overleaf to enable us to establish if the carer looking after your patient qualifies for the Respite Care Grant.

The medical information provided will be treated in strictest confidence. Although a confidential document, both medical and non-medical people may 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 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, Respite Care Grant differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with an incapacity.

If you feel that a bare outline of the incapacity 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 **Respite Care Grant Section** directly at **(01) 673 2222**.

Note:

The carer should already have filled Parts 1, 2 and 3 of the application form. The person being cared for must have completed Part A of this medical report.

Data Protection and Freedom of Information

We, the Department of Social and Family Affairs will treat all information and personal data which you give as confidential. We will only disclose it to other bodies in accordance with law. We are responsible for your information under the Data Protection Act and Freedom of Information Act.

Part B

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. How long has the person been incapacitated? ☐ less than 6 months ☐ more than 6 months

If less than 6 months, state date incapacity started ☐☐ Day ☐☐ Month ☐☐☐☐ Year

4. How long do you expect this incapacity to continue? ☐ less than 6 months ☐ more than 6 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
- 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 B

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 examination by one of our medical assessors may be required to determine eligibility for the Respite Care Grant.

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

If 'No', give details here:

Your signature

(**not** block letters)

Date

DSFA Panel Number

Address

Doctor's Official Stamp