Application form for
Carer's Benefit

How to complete application form for Carer's Benefit.

- Please read information booklet **SW 49** before filling in this application form.
- Please use **BLACK** ball point pen.
- Please tear off this page and use as a guide to filling in this form.
- Please use BLOCK LETTERS and place an X in the relevant boxes.
- Please answer **all questions** that apply to you. If you fail to do so, the form may be returned to you. If a question does not apply to you, please leave the answer area blank.
- The Department may use any of your contact details to get in touch with you.
- Please apply for Carer's Benefit as soon as you start caring duties.
  You could lose payment if you don't.
- Part 1 - Please fill in all details, following the instructions for the first page. Please sign declaration when form is completed.
- Part 2 - Please have your most recent or current employer complete this section.
- Part 3 to 5 - Please fill in all details.
- Part 6 - Please fill in all relevant details.
- Part 7 - Please tick all boxes that apply to you. Note that you must only include a birth certificate or marriage certificate if you were born or married outside the Republic of Ireland.
- Part 8 - Please have the person or people receiving care fill in Section A. Please have their doctor fill in and sign Section B.

If you need any help to complete this form, please contact your local Social Welfare Office or the Carer's Benefits Section at Longford (043) 34707 or (043) 35578.

How to fill in first page of this form

- Print letters and numbers clearly.
- Complete the boxes from left to right starting with the first box.
- Use one character per box.
- Please see example below.

1. Please state your PPS No: 1 2 3 4 5 6 7 T

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

2. Surname: MURPHY

3. First name(s): MARY

4. What is your birth surname? MCDERMOTT

5. What is your mother's birth surname? OSULLIVAN

6. What is your date of birth? (Please attach your birth certificate if born outside the Republic of Ireland) 28 (DD) 02 (MM) 1970 (YYYY)

Contact Details:

7. What is your address?

1 NEW STREET
OLD TOWN
CO DONEGAL

8. What is your telephone number?

0170430000 (LANDLINE)
0861234567 (MOBILE)

9. What is your email address? MMURPHY@WELFARE.IE

Application form for

Carer's Benefit

Social Welfare Services
CARB1

Part 1 Your own details

1. Please state your PPS No:

Title: (insert an 'X' or specify)

Mr. ☐ Mrs. ☐ Ms. ☐ Other

2. Surname:

3. First name(s):

4. What is your birth surname?

5. What is your mother's birth surname?

6. What is your date of birth? (Please attach your birth certificate if born outside the Republic of Ireland)

D D M M Y Y Y Y

Contact Details:

7. What is your address?

8. What is your telephone number?

L A N D L I N E

M O B I L E

9. What is your email address?

Declaration by you

All the information I have given on this form is accurate. I will tell the Department as soon as possible if my means or circumstances change.

I declare the person(s) named in Part 6 require(s) full-time care and attention. I am the person providing full-time care and attention.

If you cannot sign your name, make a mark, such as an X, and have a witness sign their name beside it.

Signature (NOT block letters)

Date: D D M M Y Y Y Y

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

Your own details

10. What country were you born in?

11. Are you?

Single ☐ Married ☐ Separated ☐ Remarried ☐
Widowed ☐ Cohabiting ☐ Divorced ☐

12. When did you get married?

D D M M Y Y Y Y

13. Have you ever claimed Carer's Benefit or Carer's Allowance before?

☐ Yes ☐ No

If 'Yes', please state:
Your claim or reference number:

Your address when you claimed:

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

Employer's name

Address

Telephone number

Please complete either question 15 or 16

15. When did you start working with your current employer (if relevant)?

Day Month Year

16. When did you start caring?

Day Month Year

17. Do you have a second employer?

☐ Yes ☐ No

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

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

Day Month Year

Part 2 — 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.

19. Please state your employee's name:

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

Figures							Letter(s)	

21. Is this employment part-time or full-time?

☐ Part-time ☐ Full-time

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

☐☐☐ Weekly ☐☐☐ Fortnightly

22. (b) If the employee is awarded carer's leave do they intend to leave work or reduce their hours?

leave employment from From To

reduce their hours From To

If your employee is reducing their hours please state number of hours to be worked per week _____ and gross weekly wages _____

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

☐ carer's leave ☐ Other _____
Please specify

24. 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						Number of weeks	PRSI Class
From			To				
Day	Month	Year	Day	Month	Year		

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		

To be completed by your most recent or current employer

25. 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 3 Your spouse's or partner's details

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

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

Surname

First name(s)

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

28. Where do they live?

Address

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

30. What is their PPS No.?

Figures							Letter(s)	

31. 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:

32. Are they in employment? ☐ Yes ☐ No

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

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

If 'Yes', please state:

Name of person or company that pays pension:

Address:

Part 4 Qualified child details

35. 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.

36. 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 5 Payments details

You can get Carer's Benefit direct to your current or deposit savings account in a financial institution or at your local post office.

Direct payment to your account in a financial institution

Name of financial institution:

Address:

Name of account holder:

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

Type of account:

Sort code (you can get this from your branch):

Account number (8 digits):

Post office payment

Name of post office:

Address:

Part 6 Details of person(s) you are caring for

Person 1

37. What is their full name?

Surname

First name(s)

38. What is their birth surname?

39. Where do they live?

40. What is their date of birth?

Day Month Year

41. What is their PPS No.?

Figures Letter(s)

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

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

43. What is their claim or reference number?

44.a) What date did caring commence?

44.b) Has anyone paid you for looking after this person since this date? ☐ Yes ☐ No

45. Is Domiciliary Care Allowance being paid for them? ☐ Yes ☐ No

If so, please supply evidence of payment from the Health Service Executive.

If not, has anyone applied for Domiciliary Care Allowance for them? ☐ Yes ☐ No

46.a) Is the person named at Question 37 attending a day care or rehabilitative centre? ☐ Yes ☐ No

46.b) Does the person stay overnight in any of these centres ☐ Yes ☐ No

Details of person(s) you are caring for

Person 1 continued

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.

If 'Yes' to 46(a) or 46(b) on previous page, please state:

Name of centre:

Address:

Telephone number of centre: Code / Number

Number of days they attend: days a week

Number of hours: hours a day

(Please attach letter of confirmation from day care centre.)

47. Does the person you are caring for live with you? ☐ Yes ☐ No

If 'No', please state:

How many hours a week do you provide care: hours a week

Distance between households:

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

If 'No", is there any other type of direct link? ☐ 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.

If you are caring for one person only, please go to Part 7

Details of person(s) you are caring for

Person 2 (if applicable)

48. What is their full name?

Surname

First name(s)

49. What is their birth surname?

50. Where do they live?

51. What is their date of birth?

Day Month Year

52. What is their PPS No.?

Figures Letter(s)

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

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

54. What is their claim or reference number?

55.a) What date did caring commence?

55.b) Has anyone paid you for looking after this person since this date? ☐ Yes ☐ No

56. Is Domiciliary Care Allowance being paid for them? ☐ Yes ☐ No

If so, please supply evidence of payment from the Health Service Executive.

If not, has anyone applied for Domiciliary Care Allowance for them? ☐ Yes ☐ No

57.a) Is the person named at Question 48 attending a day care or rehabilitative centre? ☐ Yes ☐ No

57.b) Does the person stay overnight in any of these centres ☐ Yes ☐ No

Details of person(s) you are caring for

Person 2 continued (if applicable)

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.

If 'Yes' to 57(a) or 57(b) on previous page, please state:

Name of centre:

Address:

Telephone number of centre: Code / Number

Number of days they attend: days a week

Number of hours: hours a day

(Please attach letter of confirmation from day care centre.)

58. Does the person you are caring for live with you? ☐ Yes ☐ No

If 'No', please state:

How many hours a week do you provide care: hours a week

Distance between households:

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

If 'No", is there any other type of direct link? ☐ Yes ☐ No

Details of direct link:

Note

If you are caring for more than 2 people, you may get Respite Care Grant for them. Please fill in CARB2 and send it to Carer's Benefit Section, Social Welfare Services Office, Ballinalee Road, Longford. You can get form CARB2 online at www.welfare.ie, by telephoning the Department's LoCall Leaflet Request Line at 1890 20 23 25 or from your local Social Welfare Office.

Part 7 Checklist of certificates and documents

If you do not send in all certificates and documents your application can not be processed and your payment will be delayed. If you are not sending in certain certificates or documents, please enclose a note stating that they will follow later. There is no need to send in certificates if the birth or marriage occurred within the Republic of Ireland.

If sending certificates or documents at a later date, please remember to state your full name, present address and your PPS No. or claim number on all correspondence. You will get your claim number shortly after you apply.

1. **Have you answered all the questions in this form, including those for your spouse or partner?** ☐ Yes ☐ No

2. **Have you ticked all the relevant answer boxes?** ☐ Yes ☐ No

3. **Have you enclosed the following certificates with your application?**

   - **Your Birth Certificate (if born outside Republic of Ireland)** ☐ Yes ☐ No
   - **Your Marriage Certificate (if married outside Republic of Ireland)** ☐ Yes ☐ No
   - **Certificate of Separation or Divorce (if relevant)** ☐ Yes ☐ No
   - **Confirmation of Domiciliary Care Allowance (if relevant)** ☐ Yes ☐ No

4. **Have you got your employer to complete part 2 of this form?** ☐ Yes ☐ No

You must sign application form in Part 1

Send the completed application form and other documents to:

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

Telephone: Longford: (043) 34707 or (043) 35578
Dublin: (01) 704 3000
extn: 48827or 49678

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

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 in accordance with law.

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 Section A completed and signed by the person(s) 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.

Part 8 Declaration by person receiving full-time care and attention

Section A (Person 1)

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 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.

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)

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 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) 34707 or (043) 35578.**

Note:

The carer should already have filled Parts 1 and 6 of the application form. The person(s) being cared for must have completed Section 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 HIS/HER APPLICATION FORM, TO THE CARER'S BENEFIT SECTION.

Section 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 admission: Day Month Year

  Date of discharge: Day Month Year

- 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:**

Section B - 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/Intelligence	☐	☐	☐	☐	☐
Consciousness/Seizures	☐	☐	☐	☐	☐
Balance/Co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐	☐
Bending/Kneeling/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:

DSFA Panel Number:

Address:

Doctor's Official Stamp

Doctor's signature

Date

(**not** block letters)

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.

Section A (Person 2)

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 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.

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 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.

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) 34707 or (043) 35578.**

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.

Medical report (Person 2)

Section 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 admission: Day Month Year

  Date of discharge: Day Month Year

- 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:

Section B - Person 2

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/Intelligence	☐	☐	☐	☐	☐
Consciousness/Seizures	☐	☐	☐	☐	☐
Balance/Co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual dexterity	☐	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐	☐
Bending/Kneeling/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:

DSFA Panel Number:

Address:

Doctor's Official Stamp

Doctor's signature

(**not** block letters)

Date

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 people or bodies in accordance with law.

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