Social Welfare Services
Dom Care 1

Data Classification
Confidential

Application form for
Domiciliary Care Allowance

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. 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.

Applicant:

You should complete **Parts 1** to **5.**

Doctor:

The child's GP should complete **Parts 6** and **7.**

To be considered medically eligible for DCA, social welfare legislation states that:

- The child must have a 'severe disability requiring continual or continuous care and attention substantially in excess of the care and attention normally required by a child of the same age'.

In support of your application, you may wish to attach copies of any medical reports you have and also a page outlining the substantial additional care you provide your child on a daily basis.

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**.

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:
0 1 7 0 4 3 0 0 0 LANDLINE
0 8 6 1 2 3 4 5 6 7 MOBILE

11. Your email address: MMURPHY@WELFARE.IE

Application form for

Domiciliary Care Allowance

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:** LANDLINE / MOBILE
11. **Your email address:**

Declaration

I certify that the child named in Part 2 resides with me and that all the information I have given on this form is accurate. I undertake to notify the Department of Social Protection of any change in circumstances which may affect my entitlement to a Domiciliary Care Allowance. I agree to any Medical Assessor of the Department conducting medical assessment(s) as considered necessary.

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 2 0 Y Y

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

Part 2 Details of the child you are claiming for

12. Child's PPS No.:

13. Child's Surname:

14. Child's First name(s):

15. Relationship to you:

16. Address (if different from yours):

17. Are you currently getting Child Benefit in respect of this child?

☐ Yes ☐ No

18. From what date has additional care been required for this child?

D D M M Y Y Y Y

If you did not make an application from the date the additional care was first required, please state the reasons why:

19. Does the child usually reside in a special school/institution at any time during the year?

☐ Yes ☐ No

If 'Yes', please state:

Average number of days per week spent in school/institution: ☐ a week

Name of school/institution:

Location:

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 either 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:

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Part 4 To be completed by you

If the child needs care and/or attention during the day or at night that is over and above what is needed by a child of the same age, please state which of the following they need help with and give details in the box provided.
Note: A separate sheet of paper can be used for more details if needed.

- **Communication (e.g. difficulty speaking or understanding, making his / her needs known):** → ☐ Yes ☐ No — Details:
- **Feeding:** → ☐ Yes ☐ No — Details:
- **Manual Dexterity (e.g. difficulty picking up objects, doing / undoing buttons / zips etc.):** → ☐ Yes ☐ No — Details:
- **Learning:** → ☐ Yes ☐ No — Details:
- **Mobility (e.g. difficulty walking, running, climbing):** → ☐ Yes ☐ No — Details:
- **Toileting:** → ☐ Yes ☐ No — Details:
- **Managing Treatment (e.g. taking tablets or medicines, home treatment programmes):** → ☐ Yes ☐ No — Details:

20.Please state how often the child attends at clinics? ☐☐☐ times a year

Part 4 continued — To be completed by you

21.Please set out the details of any other care and attention needed by the child:

If the child is attending any of the following services, please state the dates of referral. Please be sure to attach any relevant reports.

Service	Date Referred	Relevant Reports Attached	
Speech and Language Therapist:		☐ Yes	☐ No
Psychologist:		☐ Yes	☐ No
Occupational Therapist:		☐ Yes	☐ No
Physiotherapist:		☐ Yes	☐ No
Psychiatrist:		☐ Yes	☐ No
Hospital Consultant:		☐ Yes	☐ No
Public Health Physician:		☐ Yes	☐ No
Special Education:		☐ Yes	☐ No
Social Worker:		☐ Yes	☐ No
Other:		☐ Yes	☐ No

If " An Assessment of Need" under the Disability Act 2005 has been carried out, please attach a copy.

Send this completed application form to:

Domiciliary Care Allowance Section
Social Welfare Services
Department of Social Protection
College Road
Sligo

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.

20K 04-11 Edition: April 2011

Part 5 Permission to release medical information

Please sign the authorisation below, which will allow your doctor to give this Department the necessary medical information for your application for Domiciliary Care Allowance.
Your doctor should then complete Part 6 and 7 of this form.
The medical information provided will be reviewed by one of our medical assessors and will be treated in strictest confidence. Although a confidential document, medical and non-medical people will need to deal with this report.
Permission: I permit my doctor to provide you, the Department of Social Protection, with medical information that may be required for my application for Domiciliary Care Allowance.

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

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

Signature (**not** block letters)

Part 6 To be completed by the child's G.P.

Dear Doctor,
To enable us, on behalf of your patient, to accurately assess their eligibility for Domiciliary Care Allowance, please complete the medical report below. The medical information provided will be reviewed by our medical assessors and will be treated in strictest confidence.

The Freedom of Information Act provides for the disclosure of medical or psychiatric information directly to your patient. Where the disclosure of the information to the patient might have a negative effect on their physical or mental health or well-being, this information may instead be given to a medical practitioner, nominated by the claimant.

1. **Patient's details**
   Surname:
   First name:
   Address:
   Date of birth: D D M M Y Y Y Y
2. **Your patient since:** D D M M Y Y Y Y
3. **Diagnosis (use BLOCK LETTERS):**
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 12 months ☐ 12-24 months
   ☐ 24-48 months ☐ indefinitely

Part 6 continued — To be completed by the child's G.P.

7. Please give:

Medical History

Surgical History

Clinical Findings

Hospital admissions

Date of most recent admission: D D M M Y Y Y Y

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

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

Attending a specialist — Details:

On Medication — Details:

Other treatment — Details:

Please attach any relevant reports.

Additional Information:

Part 7 Medical Report

9. Indicate the degree to which your patient's condition has affected their ability in each of the following areas. (Should ability in any area be inappropriate to the age of the child, please tick N/A).

	Normal	Mild	Moderate	Severe	Profound	N/A
Mental health/Behaviour →	☐	☐	☐	☐	☐	☐
Learning/Intelligence →	☐	☐	☐	☐	☐	☐
Consciousness/Seizures →	☐	☐	☐	☐	☐	☐
Balance/Co-ordination →	☐	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐	☐
Manual dexterity →	☐	☐	☐	☐	☐	☐
Lifting/Carrying →	☐	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting →	☐	☐	☐	☐	☐	☐
Sitting →	☐	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐	☐
Climbing stairs →	☐	☐	☐	☐	☐	☐
Walking/Crawling →	☐	☐	☐	☐	☐	☐

Doctor's name.

DSP panel number

Address:

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

Date: ☐☐ ☐☐ 2 0 ☐☐
D D M M Y Y Y Y

Doctor's official stamp

All information given in this section is covered by the Data Protection Act and the Official Secrets Act.

For Official use Only

1. Customer PPSN No.:

2. Diagnosis:

3. ICD10 Code(s):

Medical Assessor's Opinion

(i) Eligible for Domiciliary Care Allowance:

(ii) Medical Review Date: D D M M Y Y Y Y

(iii) DNRA:

(iv) Not eligible for Domiciliary Care Allowance:

Give reasons:

Signed _____ **Medical Assessor**

Date: D D M M 2 0 Y Y

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