Department of Social and Family Affairs

Aras Mhic Dhiarmada
Store Street
Dublin 1

Medical Eligibility Guidelines for Domiciliary Care Allowance

Report of the Expert Medical Group

Please note: These guidelines were revised in May 2013 at the request of the Minister for Social Protection, in line with recommendations made to her in the report of the review group on the Domiciliary Care Allowance scheme, which was submitted in December 2012. The review of the medical guidelines was informed by input from a number of relevant practicing medical experts in the field of childhood disability. The following recommendations in relation to changes to the original medical guidelines are now being implemented:

Appendix 6 (Pages 25, 26 of the report)

The "Normal Age of Attainment" data referred to, is replaced with by reference to the guidelines used by the Centres for Disease Control and Prevention (CDC) Child Development. Details of which are available on their homepage using the following link:

Age 0-5 http://www.cdc.gov/ncbddd/actearly/milestones/index.html

Age 6 – 8 http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle.html

Age 9-11 http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle2.html

Age 12-14 http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence.html

Age 15 – 17 http://www.cdc.gov/ncbddd/childdevelopment/positiveparenting/adolescence2.html

Appendix 8 (Pages 28, 29, 30)

The listing of conditions 'more likely' and 'less likely' to result in a disability that requires the level of extra care and attention required to qualify for the allowance is deleted and will not be referenced in future assessments by medical assessors.

These revisions become operational on the date of publication.

Dr Clement Leech

Chief Medical adviser

31st March 2014

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Acknowledgements

The Expert Medical Group wishes to acknowledge the contribution the Guidelines for Community Public Health Doctors assessing eligibility for Domiciliary Care Allowance in the Southern Health Board region 2004 made to the development of these guidelines. The Public Health Doctor's guidelines were compiled by a Senior Medical Officer/Area Medical Officer (SAMO/AMO) working group which was chaired by Dr Maeve Burke SAMO.

Final drafts of the report were reviewed by:

- Professor Mansel Aylward, CB MD FFOM FRCP Hon FFPH DDAM, Director of Unum Centre for Psychosocial and Disability Research (CPDR), University of Cardiff. Professor Aylward is also a former Chief Medical Adviser, Department of Work and Pensions, U.K.

- Dr. Emma Curtis, MB BCh MRCPI DCH, Consultant Paediatrician National Childrens' Hospital AMNCH Tallaght Dublin 24.

Chapter 1 Introduction

Transfer of Domiciliary Care Allowance from the Health Service Executive to the Department of Social and Family Affairs

1.1. A Government Decision on the Structural, Organisational, Financial Management and Systems Reform of the Health Sector, dated June 2003, acknowledged that in order to increase the effectiveness of the health service generally, and its capacity to deliver the reform agenda, it was important that the service concentrated fully on addressing its core health objectives. Accordingly it was felt that there could be scope to transfer certain functions out of the health service and locate them more appropriately within other Government Departments.

1.2. As part of the overall decision, it was agreed that a working group would be established, to include the Departments of Health and Children, Finance and An Taoiseach, to examine the scope for the transfer of certain activities to other, more appropriate, Departments and agencies and that on completion of this review, the Minister for Health and Children would bring proposals to Government.

1.3. The subsequent Core Functions of the Health Service Report (2006) found that there were a number of income support and maintenance schemes being administered and / or funded through the health services which were seen to be more welfare supports than personal social services. A range of supports were considered for transfer to the Department of Social and Family Affairs and it has been decided that Domiciliary Care Allowance will transfer to the Department of Social and Family Affairs during 2009. The Department of Health and Children, the Health Service Executive and the Department of Social and Family Affairs are currently working through the detailed implementation plan and this work will bring about the transfer.

Opportunities Arising

1.4 From the Department of Social and Family Affairs point of view, in order to get the maximum dividend from the transfer of Domiciliary Care Allowance it is essential to consider its potential for integration into the range of services that the Department of Social and Family Affairs provides in the most efficient, effective and equitable way. As with any area of social policy, the recommendation to transfer the payments to the Department of Social and Family Affairs arises within the context of other related, and broader, considerations. They include improving value for money and creating a more integrated and efficient service to customers.

Chapter 2 Background

Domiciliary Care Allowance (as it currently operates in the Health Service Executive)

2.1 Domiciliary Care Allowance is a monthly allowance introduced in 1973 and administered by the Health Service Executive across 32 Local Health Office Areas organised into four regions. Circulars issued by the Department of Health and Children set out in some detail the guidelines for the administration, eligibility conditions and rates of payment of the scheme. The most up to date circular is attached at Appendix 1. Statistical information on the allowance is at Appendix 2.

2.2 Eligible children from birth to the age of 16[1] who are living at home and who have a severe disability requiring continual or continuous care and attention which is substantially in excess of that normally required by a child of the same age may qualify for Domiciliary Care Allowance. The condition must be likely to last for at least one year.

2.3 Where medical confirmation is supplied which pre-dates the actual date of application and the Health Service Executive`s Senior Medical Officer is satisfied that the child required continual or continuous care and attention, substantially in excess of that normally required by a child of the same age, then payment may be made from the date the Senior Medical Officer is satisfied that such additional care and attention was required. However, from November 2008 the HSE have been approving Domiciliary Care Allowance payments from:

(i) the date an application for the allowance was made or
(ii) in certain individual circumstances backdating for a maximum of 6 months before the date of application.

2.4 Eligibility is determined primarily by reference to the degree of additional care and attention required by the child rather than to the type of disability involved, subject to the means test. While no condition is debarred, conditions such as Asthma, Diabetes or Epilepsy are not normally considered unless there is a very high degree of additional care and attention required.

2.5 As the process will change on transfer from a locally based administration system to a centrally based one, the opportunity arises to prepare guidelines to ensure a consistent and equitable treatment of customers nationally. These guidelines should address the issues around perceived inconsistencies that have arisen in the past and that were difficult to solve in a locally based administration system.

Interaction between Groups dealing with the Transfer

2.6 The Expert Medical Group which been set up under the Inter Departmental Implementation Group that has been charged with overseeing the transfer of Domiciliary Care Allowance and a number of other income support and maintenance payments. The Inter Departmental Group is chaired by the Department of Health and Children. Regular updates are given to this Group on behalf of the Expert Medical Group and any issues arising are discussed and agreed.

[1] Up to January 2000 children from age 2 to age 16 were eligible for Domiciliary Care Allowance. From January 2000 the age criteria was extended to include children from birth.

2.7 The Department of Social and Family Affairs Policy Committee has decided that from a policy point of view the transfer of Domiciliary Care Allowance will be done on an "as is" basis. In practical terms this means that "*children from birth to the age of 16 who are living at home and who have a severe disability requiring continual or continuous care and attention which is substantially in excess of that normally required by a child of the same age"* continue to be the target group as regards medical eligibility. Medical eligibility criteria for the allowance have not been extended or restricted. What has been prepared by the Group is a consistent and transparent set of guidelines which can be applied to applications.

2.8 A separate Group in the Department of Social and Family Affairs is dealing with the administrative aspects of the transfer and setting up new processes for administering the Allowance post transfer. There was ongoing communication between this Group and the Expert Medical Group to ensure that the Medical Guidelines were feasible from an administrative point of view. In addition, administrative staff attended all meetings of the Expert Medical Group resulting in an understanding of what was medically and administratively feasible.

Future roles in the Assessment Process

2.9 The definition of "medical" used in this report is the modern definition. It therefore includes the physical, psychological and social aspects of the condition.

2.10 Currently Medical Officers in the Health Service Executive assess medical eligibility for Domiciliary Care Allowance and the Senior Medical Officer determines whether the criteria of continual, continuous care and attention, substantially in excess of that required by a child of the same age have been satisfied. It is envisaged that post transfer this assessment role will be carried out by Department of Social and Family Affairs Medical Assessors. These Medical Assessors will make a recommendation to a Deciding Officer as to whether the child meets the medical eligibility criteria or not.

2.11 The Medical Assessor's recommendation will be based on information contained as part of the application. This information will include:

- Personal details supplied on the application form by the child's parent / guardian.
- Details of the additional care and attention required by the child as outlined by the parent / guardian on the application form.
- Medical details provided by the child's G.P. and included in the application form.
- Any additional information the parent / guardian considers relevant to the application. This could include consultant's reports, reports from a Community Health Doctor, a copy of the needs assessment carried out by the HSE etc.

Chapter 3 Expert Medical Group

Terms of Reference

3.1 In order to ensure that a centralised, consistent set of guidelines are implemented by the Department of Social and Family Affairs post transfer, an Expert Medical Group was set up. The Group was asked to do the following:

- Arrive at a consensus regarding guidelines to determine the medical eligibility to qualify for Domiciliary Care Allowance.
- Facilitate the efficient and effective processing of applications by considering:
  - conditions which are **more likely** to result in a child requiring continual or continuous care and attention substantially in excess of that required by a child of the same age.
  - conditions which are **less likely** to result in a child requiring continual or continuous care and attention substantially in excess of that required by a child of the same age.

Membership of the Group

3.2 The Group was chaired by Dr. Clement Leech, Chief Medical Adviser of the Department of Social and Family Affairs. A Principal Medical Officer and a Senior Medical Officer currently working for the Health Service Executive, who have experience of deciding medical eligibility for Domiciliary Care Allowance were also members of the Group. This ensured that the Group had a full picture of how Domiciliary Care Allowance currently operated and understood the issues that arise in the current operation of the scheme. A Consultant Child Psychiatrist and an International Expert on Disability Assessment were also members of the Group.

Membership of the Group

Medical : -	Dr. Clement Leech, Chief Medical Adviser, Department of Social and Family Affairs (Chair).
	Dr. Roger Thomas, Honorary Senior Research Fellow, Centre for Psychosocial and Disability Research, Cardiff University.
	Dr. Colette Halpin, Consultant Child Psychiatrist, Midland Regional Hospital, Portlaoise.
	Dr. Peter Nolan, Principal Medical Officer, HSE PCCC Directorate, Dublin NE.
	Dr. Brett Lynam, Senior Medical Officer, Community Services, HSE South.
Administrative Liaison:-	Phil Cox[2], Principal, Core Functions Prog, Department of Social and Family Affairs.
	Vincent Clohisey[3], Principal, Core Functions Prog, Department of Social and Family Affairs.
Secretary to the Group:-	Elaine Soffe, Assistant Principal, Core Functions Prog, Department of Social and Family Affairs.

[2] Phil Cox took up new duties within the Department of Social and Family Affairs in October 2008 and so resigned from the Group.
[3] Vincent Clohisey replaced Phil Cox on the Group in October 2008.

Timescales and Meetings

3.3 The Expert Medical Group met on six occasions between April and October 2008.

International Comparison

3.4 An international comparison was carried out by the Group. This involved research being carried out to ascertain if payments made to families with children with disabilities in other countries were structured in a similar way to Domiciliary Care Allowance. The Group found that payments in several other countries were structured on a tiered basis with different rates of payment going to families depending on the severity of the child's disability. This structure necessitated a more detailed assessment process than is necessary for Domiciliary Care Allowance.

Chapter 4 Lifecycle of an Application

Making an Application

4.1 A parent / guardian wishing to apply for Domiciliary Care Allowance from the Department of Social and Family Affairs must do the following:

- Get a copy of the Domiciliary Care Allowance application form from the internet, their local Social Welfare Office, Health Centre etc.
- Fill in the "Personal Details" part of the application form.
- Describe the extra care and attention which is required by the child.
- Sign the form.

4.2 Should the parent / guardian require assistance with filling out the form, it is in order for them to do so. Where a third party completes the form on behalf of the parent / guardian, the third party and the parent / guardian must both sign the form.

4.3 The parent / guardian should then:

- Bring the form to the child's G.P. and arrange for the medical part of the form to be completed.
- Include any reports from specialists and other health care professionals that are available and submit with the application.
- Send all documents to the Department of Social and Family Affairs for assessment.

4.4 Extracts of the type of information to be included in the application form are set out at Appendix 3. In addition, Appendix 4 sets out the different types of information that can be used during the application process. ***It is in the interest of the applicant to supply as much relevant information as possible with the application.*** This will assist the Department to deal efficiently with the application. A checklist will be included with the application form to assist the parent / guardian to attach all relevant information.

Desk Assessment

4.5 On receipt of the application, the Department of Social and Family Affairs will endeavour to ensure that it is dealt with in a timely manner through a desk assessment process which will be specifically designed for this purpose. The Group is satisfied that, when all circumstances are taken into account, the most appropriate way to conduct assessments for medical eligibility is by desk assessment. The application form, together with any additional supportive evidence furnished, will form the basis for the decision. An overview of the desk assessment part of the process is outlined in Appendix 5.

Role of the Medical Assessor

4.6 In assessing each case the Medical Assessor will review the history of the case, consider all reports received (including the description of the care and attention required by the child given by the parent / guardian), and express an opinion as to whether the child meets the medical criteria

set out in the relevant legislation. In doing this, the Medical Assessor assesses whether or not the child's condition results in their requiring continual or continuous care and attention which is substantially in excess of that normally required by a child of the same age. The Office for Population Censuses and Surveys study on Disability in Childhood in the UK has compiled a table setting out "normal age of attainment" data (i.e. the age by which 90% of children can perform activity) across a range of activities for children less than 5 years. A copy of the table is attached at Appendix 6. This type of information should be useful to the Medical Assessor as part of his / her assessment of the case.

4.7 The Medical Assessor is not involved in advice or treatment.

4.8 Should the Medical Assessor recommend eligibility for Domiciliary Care Allowance, he / she should also recommend a date of award and a review date.

Role of the Deciding Officer

4.9 The role of the Deciding Officer, set out in Section 300 of the Social Welfare Consolidation Act, 2005, is to make the decision on entitlement based on the information received from the child's parent / guardian, any supporting information included with the application and the recommendation of the Medical Assessor. The Deciding Officer notifies the applicants of the decision. Where a decision to award Domiciliary Care Allowance is made, the Deciding Officer will also notify the applicant of the date of award and rate of payment.

4.10 Where an applicant is not satisfied with the decision of a Deciding Officer they can appeal the decision. The appeal will be dealt with in the first instance by another Medical Assessor. If the applicant is still not satisfied with the decision, the decision can then be appealed to the Social Welfare Appeals Office. The Social Welfare Appeals Office is a statutorily defined office which operates independently of the Department of Social and Family Affairs. It aims to provide an independent, accessible and fair appeals service for entitlement to social welfare payments.

Chapter 5 Guidelines

Legislation

5.1 Sections 15 to 17 of the Social Welfare and Pensions Act, 2008 set out the eligibility conditions for Domiciliary Care Allowance which will apply post transfer. These conditions require that, to be eligible for payment a medical practitioner must certify that:-

(i) the child has 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,

and

(ii) the disability is such that the child is likely to require full-time care and attention for at least 12 consecutive months.

Definitions

5.2 Each of the terms in the legislative requirements outline above are explained below, using clear language so that potential applicants and decision makers can understand what is required.

5.3 The Group examined a number of definitions of disability that are in use in Ireland, the UK and internationally. It was agreed that Domiciliary Care Allowance is not awarded primarily on the basis of an impairment or disease, but on the resulting lack of function of body or mind necessitating a degree of extra care and attention required.

5.4 There was agreement that the World Health Organisation was the closest definition of disability to what was required. This decision was based on the importance of including the word "impairment "in the definition and making sure the definition was suitable for children.

5.5 The Group agreed that the definition of "impairment" used by the World Health Organisation would be used:

"*Any abnormality of, partial or complete loss of, or loss of the function of, a body part, organ, or system*".

5.6 After some consideration, the definition of disability agreed was:-

"*Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a child compared to a child of the same age*."

5.7 The Oxford English Dictionary descriptions of "severe" were discussed – serious, critical, extreme in an unpleasant way. These phrases could be used in the proposed guidelines to describe the nature of eligible disabilities.

5.8 The provision of care and attention for Domiciliary Care Allowance must be continuous or continual. Definitions of both words were examined. These definitions would appear to allow for "brief" interruptions to the care and attention being provided.

5.9 Care and attention needs would not meet the eligibility criteria if they related solely and individually to bringing a child to school or to social activities or helping with homework.

5.10 The Group noted the definition of "substantial" as described in the Oxford English Dictionary as "of large size or amount". They endorsed its use in respect of the degree care and attention that is required because of the child's severe disability.

5.11 An awareness of what type / level of care is required by children of different ages is required in order to establish what is "substantially in excess". To assist the Medical Assessor, a guide to the normal age of attainment of certain activities, compiled as part of the Office for Population Censuses and Surveys study on Disability in Childhood in the UK, is attached at Appendix 6.

In Summary

5.12 All children require a certain amount of care and attention but children with severe disabilities may require substantially more care and attention.

5.13 ***In order to qualify for Domiciliary Care Allowance a child must have a disability so severe that it requires the child needing care and attention and / or supervision substantially in excess of another child of the same age. This care and attention must be given by another person, almost all of the time, so that the child can deal with the activities of daily living. The child must be likely to require this care and attention for at least 12 months.***

Codes and Categories

5.14 It was agreed by the Group that in order to ensure clarity and consistency in decisions, codes and categories would be used.

5.15 It was agreed that ICD 10 codes would applied to the child's primary condition. These ICD 10 codes were chosen because they are internationally recognised, they are currently in use in some areas of the HSE and they will facilitate the collation of statistical information. Coding will be closely scrutinised by the Medical Assessor at desk assessment.

5.16 It is important that codes, where available, are applied to the stock of claims which will be transferred from the Health Service Executive. These codes will inform the review policy for these claims.

5.17 It is desirable that, in cases where mental health, behavioural and emotional disorders are present, the multi axial diagnostic classification system should be used. A sample of this system is attached at Appendix 7.

5.18 To assist the Medical Assessor at desk assessment in determining eligibility for Domiciliary Care Allowance, primary conditions are categorised into those which are more likely to result in a disability so severe that the child requires continual or continuous care and attention substantially in excess of the care and attention normally required by a child of the same age, and those which are less likely to result in the child requiring such care.

5.19 Details of these categories are set out at Appendix 8. This is not, however, an exhaustive list. It may be necessary to provide more detail over time.

Date of Award

5.20 As a general rule the date of award should be the date of application. In extreme circumstances it may be possible to backdate a claim.

5.21 From November 2008 the HSE have been approving Domiciliary Care Allowance payments from:

(iii) the date an application for the allowance was made or
(iv) in certain individual circumstances backdating for a maximum of 6 months before the date of application.

This is similar to the arrangements that are in place for other Social Welfare payments in circumstances where a “late claim” is received.

5.22 Social Welfare legislation makes provision to allow payment within certain limits where there was 'good cause' for the late claim. The term 'Good cause' is not defined in the legislation, and must be assessed by Deciding Officers by the application of common sense principles to the contentions put forward by the person concerned and by the evaluation of the evidence available to support those contentions. There are five main headings under which “good cause” is normally considered. These five headings and a short explanation is attached at Appendix 9.

5.23 The Group recommends that the date of application is the most appropriate date of award with provision made to backdate for 6 months only in exceptional circumstances.

Reviewing Claims

5.24 In order for Domiciliary Care Allowance to be awarded, the appropriate level of care and attention must be required for at least one year. The minimum review date possible is therefore one year. Periodic reviews of eligibility for payment will be undertaken as deemed appropriate.

Appendix 1

Department of Health and Children Domiciliary Care Allowance Circular January 2007

Establishment and Legal Basis
The Domiciliary Care Allowance (DCA) was introduced in 1973 by way of Circular 24/73 (superseded by this circular/guideline) and is payable under Section 61 of the Health Act, 1970.

Criteria and Eligibility:
Domiciliary Care Allowance is a monthly allowance administered by the Health Service Executive. Eligible children from birth to the age of 16 who are living at home and who have a severe disability requiring continual or continuous care and attention which is substantially in excess of that normally required by a child of the same age may qualify for DCA. The condition must be likely to last for at least one year. Where medical confirmation is supplied which pre-dates the actual date of application and the Health Service Executive`s Senior Medical Officer is satisfied that the child required continual or continuous care and attention, substantially in excess of that normally required by a child of the same age, then payment may be made from the date the Senior Medical Officer is satisfied that such additional care and attention was required.

Eligibility is determined primarily by reference to the degree of additional care and attention required by the child rather than to the type of disability involved, subject to the means test. While no condition is debarred, conditions such as Asthma, Diabetes or Epilepsy are not normally considered unless there is a very high degree of additional care and attention required.

Pro-Rata Payment:
Since the allowance is intended as a recognition of the additional burden involved in caring for children with a severe disability in the child's home, it does not apply to children who are maintained full time in residential homes, schools or other centres. Eligible children in part-time residential care who go home at weekends or holidays may receive a pro-rata payment, i.e. a per nightly rate based on the number of nights spent at home (nightly rate is equal to the monthly rate multiplied by 12 and divided by 365).

Pro rata payments should be paid in arrears, subject to validation by the school/centre principal.

HOWEVER, THE ALLOWANCE IS PAID IN FULL IN CASES WHERE ELIGIBLE CHILDREN WHO LIVE FULL TIME AT HOME ARE ABSENT FOR A PERIOD/S OF NOT MORE THAN 8 WEEKS IN ANY 12 MONTH PERIOD, I.E. HOSPITAL ADMISSIONS OR RESPITE.

The Health Service Executive may consider continuing payment of the allowance in cases of extreme hardship where an eligible child spends more than 8 weeks in hospital in any 12 month period, and where the parent(s)/guardian have to regularly travel long distances to visit the child in the hospital.

The Christmas Bonuses and Annual Increases will be implemented, if appropriate.

Where a beneficiary of DCA transfers residence from a Health Service Executive Area (A) to another Health Service Executive Area (B) it will not be necessary for that person to re-apply to Health Service Executive Area (B) for the DCA. The person should write to Health Service Executive Area (B) indicating that he/she has transferred residence there from Health Service Executive Area (A) where he/she was receiving DCA. Health Service Executive Area (B) should request the appropriate file from Health Service Executive Area (A) and should commence payment of the DCA from the date after Health Service Executive Area (A) ceased payment. Medical and financial reviews should be carried out in the normal way as required.

Children approaching 16

Entitlement to Domiciliary Care Allowance ceases on the child's 16th birthday.

When the child is approaching the age of 16 he/she should be advised to apply for Disability Allowance (DA) to DSFA. The Health Service Executive should notify the parent(s) / guardian(s) of the child at least 6 months prior to the child's 16th birthday. However, the claimant must satisfy the means test and medical criteria.

Procedure:

- The application form for Domiciliary Care Allowance should be accessed by the client or their parent/guardian at local Health Service Executive offices, completed and submitted to the appropriate Community Services Office.
- Administration must send the applicant an acknowledgement of receipt of the application.
- Administration should then pass the application to the S.M.O. for medical assessment based on the medical eligibility criteria.
- On completion of the medical assessment, the S.M.O. should return it to administration.
- The Health Service Executive`s relevant authorising officer(s) for the area should then make the decision on entitlement, based on the information received from the S.M.O. and from Community Welfare Services/appropriate section (where relevant) and the eligibility criteria.
- In relation to successful applicants, the Health Service Executive`s relevant authorising officers will notify the applicants as to the rate of payment, the date of commencement of entitlement (including any details in relation to means and the calculation thereof).
- DCA is then put in payment from the appropriate date.
- Administration should issue an application form for Disability Allowance to the parent(s) 6 months prior to the child's 16th birthday with a letter advising that DCA will cease on the child reaching 16 years of age.

What is the means test?[4]

Only the personal means of the child are taken into account. The means of the parents are not considered. Children who have means of their own in excess of the amount of the allowance are not eligible. Where children have means below the amount of DCA payable, the amount of determined means is deducted from the amount of maximum DCA payable. The means of the child includes payments of compensation following court action or otherwise in respect of injuries or disabilities sustained by the child, inheritance etc. Such monies are assessed on the basis of the investment value, i.e. annual interest obtained. The annual interest obtained should be divided by 12 to give a monthly value. This monthly value should be deducted from monthly DCA payment on a Euro per Euro basis.

The following should NOT be considered as means, where applicable:

- Monies received from charitable organisations other than remuneration.
- Special Compensation awards that are exempted by legislation, e.g. Hep. C, etc.
- Supplementary Welfare Allowance in respect of the child.
- The benefit of the Disabled Drivers & Disabled Passengers (Tax Concessions) Scheme.
- Foster Care Allowance
- Repayments received under the Health (Repayment Scheme) Act 2006.

Who Receives DCA Payment?

Payment of DCA is paid to the person who is providing continuous care and attention. It is normally paid to the mother of the child but at the discretion of the Health Service Executive, it may be paid to the father. A Foster Parent can also be a beneficiary of DCA. Payment is made on a calendar monthly basis. Any additional eligible children in the family should also receive the maximum DCA amount payable, subject to the same personal means assessment.

[4] Post transfer no means test will apply as per the Social Welfare and Pensions Act, 2008.

Review Process:
Reviews should be carried out periodically based on the recommendation of the appropriate designated officer(s).

Appeals:
Applicant must be notified (in writing) of the outcome of any decision on application or review (favourable and unfavourable). In the event of an unfavourable decision, formal notification should be issued informing the applicant of his/her right of appeal and indicating where he/she should send the appeal.

Appendix 2 – Statistics

Number of Children in respect of whom Domiciliary Care Allowance is paid

Trends by Quarter – June 07 to December 08

Former Health Board Area	June 07	Sept 07	Dec 07	March 08	June 08	Sept 08	Dec 08	Increase Jun 07 to Dec 08
ERHA	5,902	6,006	6,374	6,297	6,394	6,542	6,767	14.66%
SEHB	2,330	2,387	2,403	2,556	2,603	2,659	2,751	18.07%
SHB	3,833	3,845	3,901	4,020	4,056	4,171	4,305	12.31%
MWHB	1,949	2,033	2,114	2,185	2,229	2,301	2,453	25.86%
Midland HB	1,138	1,182	1,226	1,352	1,288	1,348	1,407	23.64%
WHB	1,852	1,932	2,078	2,163	2,192	2,254	2,275	22.84%
NWHB	1,109	1,135	1,174	1,198	1,216	1,215	1,275	14.97%
NEHB	1,618	1,735	1,770	1,810	1,824	1,888	1,902	17.55%
Total	19,731	20,255	21,040	21,581	21,802	22,378	23,135	17.25%

Number of Children in respect of whom Domiciliary Care Allowance is paid

Annual Trends – 2000 to 2008

Year	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total All Areas	11,217	12,000	11,100	14,233	15,766	18,000	18,413	21,040	23,135
Increase on previous year		7.0%	-7.5%	28.2%	10.8%	14.2%	2.3%	14.3%	9.96%

Appendix 3 – Extracts from Proposed Application Form

To be completed by the child's Parent / Guardian

Describe the degree of care and attention required by your child in the areas outlined below.
Communication (e.g. difficulty speaking or understanding, making his / her needs known):
Feeding:
Manual Dexterity (e.g. difficulty picking up objects, doing / undoing buttons / zips etc.):
Learning:
Mobility (e.g. difficulty walking, running, climbing):
Toileting:
Managing Treatment (e.g. taking tablets or medicines, home treatment programmes):
Frequency of attendance at clinics:

Please set out details of any other care and attention needed by your child:-

To enable us to deal with your application effectively and efficiently it is in your interest to supply us with any supplementary information that may be available. To assist you in this regard, please see the check list below.

Attach any reports available from:-	
Speech and Language Therapist	
Psychologist	
Occupational Therapist	
Physiotherapist	
Psychiatrist	(e.g. Multi Axial Report)
Hospital Consultant	
Public Health Physician	
Special Education	
Social Worker	
If “An Assessment of Need” under the Disability Act has been carried out, please attach a copy.	
Other	

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

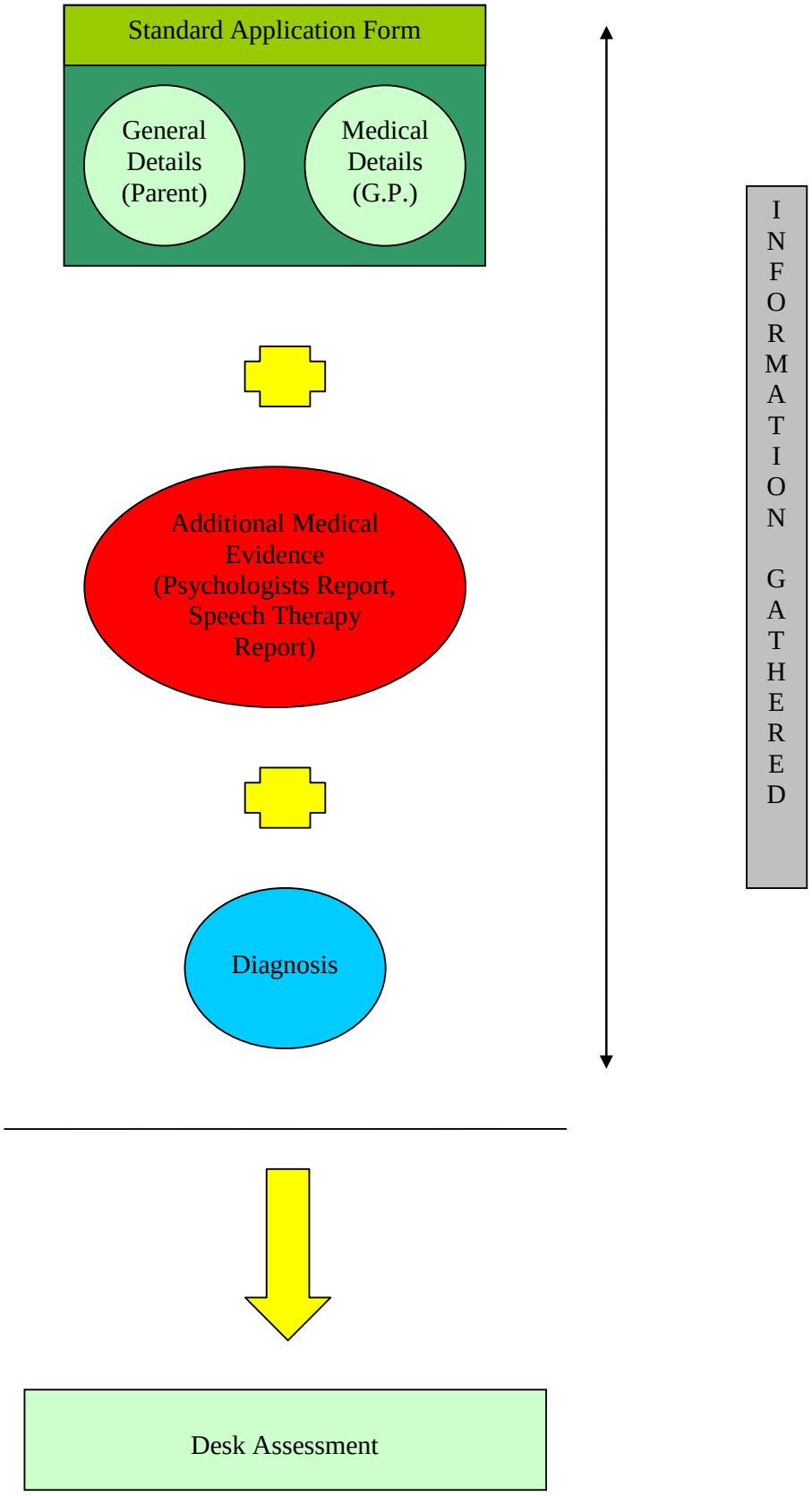
Name Address Date of Birth Your patient since:		
Diagnosis (use block capitals) ICD 10 Code if available		
How long do you expect this condition to continue?	Less than 12 months 24-48 months	12-24 months indefinitely
Medical History and Treatment		
Surgical History		

Clinical Findings	
Hospital admissions	Date of most recent admission: Date of discharge:
Attending a specialist	Details:
On medication	Details:
Other treatment	Details:
Please attach any relevant reports	
Additional Information	

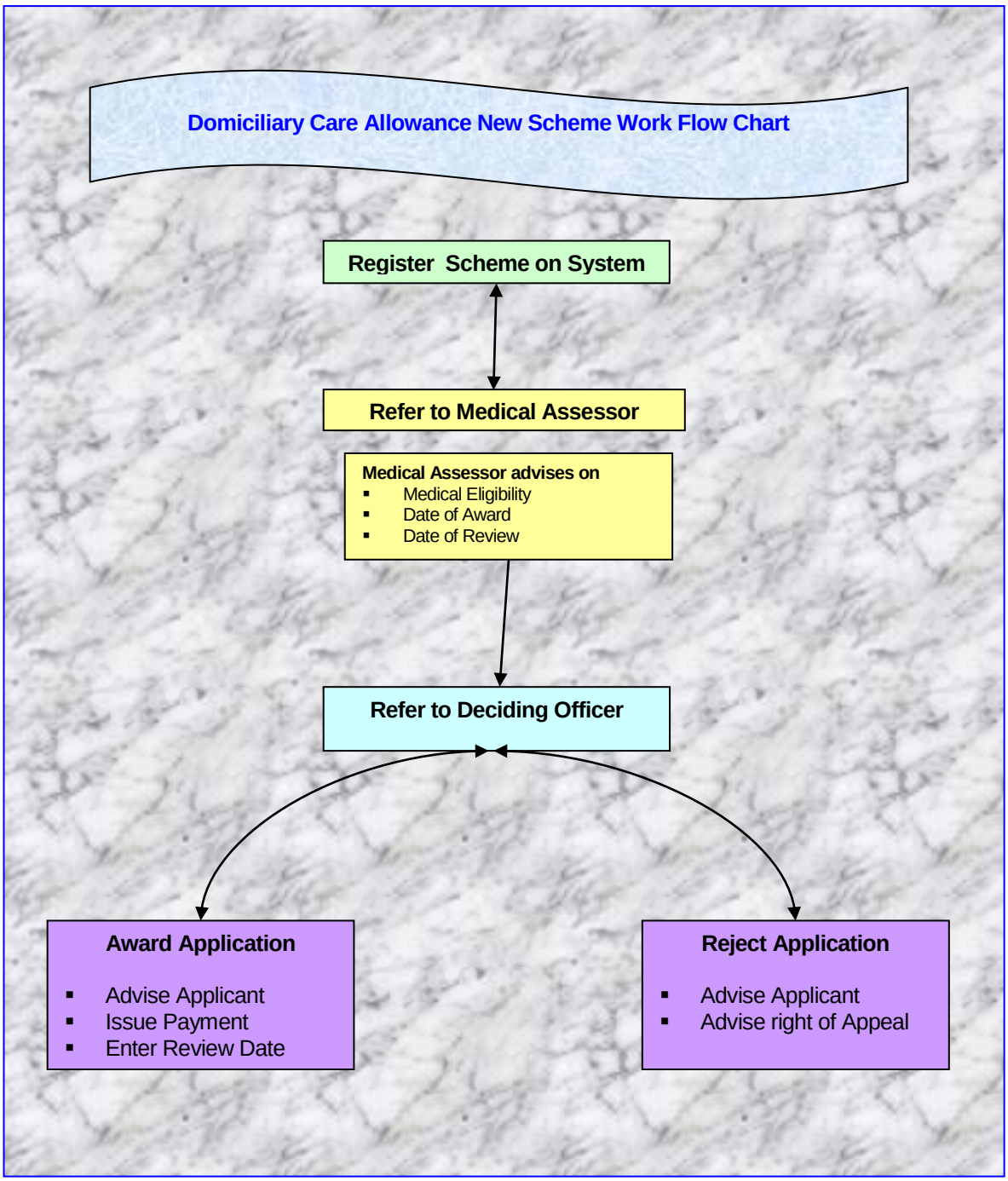
Indicate the degree to which the child's condition has affected his/her ability in each of the following areas. (Should ability in any area be inappropriate to the age of the child, please tick N/A).

	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						
Climbing stairs						
Walking / Crawling						

Appendix 4 – Information which can be used during the Application Process



Appendix 5


Domiciliary Care Allowance New Scheme Work Flow Chart
Register Scheme on System
Refer to Medical Assessor
Medical Assessor advises on
Medical Eligibility
Date of Award
Date of Review
Refer to Deciding Officer
Award Application
Advise Applicant
Issue Payment
Enter Review Date
Reject Application
Advise Applicant
Advise right of Appeal

Appendix 6

DELETED (May 2013) and replaced with by reference to the guidelines used by the Centres for Disease Control and Prevention (CDC) Child Development. Details of which are available on their homepage using the following link:

http:/www.cdc.gov/ncbddd/childdevelopment/positiveparenting/middle2.html

'Normal age of attainment' – age by which 90% of children can perform the activity[5]

Communication	Normal age of attainment
Tell you what he has been doing / what has happened	38 Months
Ask questions	24 Months
Join two or more words together to make sentences	24 Months
Say a few simple words	16 Months
Understand people outside the family	36 Months
Understand what mother says to him	30 Months
Understand things asked to do like 'fetching things from another room'	18 Months
Understand simple things asked him to do like 'say bye-bye'	12 Months
Understand things like 'no-no'	9 Months

Continence	Normal age of attainment
Wets the bed every nights, but does not wet self by day.	36 Months
Wets the bed at least once a week, but does not wet self by day	36 Months
Wets the bed at least once a month but does not wet self by day	36 Months
Wets self every day	27 Months
Wets self during the day at least once a week	27 Months
Wets self during the day at least once a month	27 Months
Cannot usually control his bowels	21 Months
Soils self at least once every 24 hours	21 Months
Soils self at least once a week	21 Months
Soils self at least once a month	21 Months

Dexterity	Normal age of attainment
Hold small bottle of fizzy drink with either hand	30 Months
Hold small bottle of fizzy drink with one hand but not the other	30 Months
Hold small building brick with either hand	6 Months
Hold small building brick with one hand but not the other	6 Months
Throw a ball	24 Months
Use pencil to draw, scribble, make marks	19 Months
Cut with scissors	36 Months
Unwrap a sweet	24 Months
Unscrew a lid	48 Months
Pick up a smartie	13 Months

[5] Compiled by the Office for Population and Censuses Surveys in the UK.

Grasp Lego and pass from hand to hand	8 Months

Reaching and stretching	**Normal age of attainment**
Stretch either arm out to reach for something in front of him	5 Months
Stretch one arm out to reach for something in front of him but not the other	5 Months
Hold out either arm to put it into sleeves of jacket	12 Months
Hold out one arm to put into the sleeve of a jacket but not the other.	12 Months
Put either hand on top of his head	9 Months
Put one hand on to of his head but not the other	9 Months

Locomotion	**Normal age of attainment**
Walk without help for ¼ mile	36 months
Walk without help for 200 yards	30 months
Walk without help for 50 yards	24 months
Walk a few steps	14 months
Walk by holding on	13 months
Stand without holding on	14 months
Stand holding on	10 months
Kick/move legs	3 months
Run more than 10 yards	30 months
Run more than 5 yards	24 months
Run a few steps	21 months
Walk up 12 stairs one foot to a step without help or holding on	42 months
Walk up with alternating feet without help	36 months
Walk up two feet to feet to a step	21 months
Walk up with hand held	18 months
Walk down 12 stairs one foot to a step without help or holding on	48 months
Walk down two feet to a step without help	36 months
Walk down two feet to a step holding on	30 months
Get down crouching or bumping	18 months
Bend squat and kneel down and get up without holding	24 months
Squat and kneel down and get up without holding	24 months
Squat or kneel	15 months.

Personal Care	**Normal age of attainment**
Eat with fork and spoon	36 Months
Eat with spoon without spilling	19 Months
Feed self biscuit with hand	7 Months
Drink from cup without help	16 Months
Drink from cup with help	11 Months
Dress and undress apart from buttons	42 Months
Put on pants and shoes apart from buckles	35 Months
Help by holding out arm for sleeve or foot for shoe	12 Months
Wash hands himself	37 Months

Appendix 7

Child and Adolescent - Multi Axial Classification System

Diagnosis in Child and Adolescent Psychiatry is usually multi axial. ICD 10 is the standard diagnostic tool used in this country.

Axis I – Clinical Psychiatric Syndrome;
e.g. Depression, Anorexia Nervosa, ADHD, Schizophrenia.

Axis II- Specific Disorders of Psychological Development;
includes disorders of speech and language, disorders of scholastic skills such as specific reading or mathematical skills problems and specific developmental disorders and motor function for example Dyspraxia.

Axis III- Intellectual Level; mild, moderate, severe and profound mental retardation. An extra character may be used to specify the extent of associated behaviour impairment where there is a mental retardation.

Axis IV – Medical conditions.

Axis V – Abnormal Psychosocial Situations;
Examples of which might be abnormal relationships in the family, mental disorders in parents or siblings, or disability. Distorted family communication, abnormal upbringing, abnormal immediate environment for example, single family, institutional upbringing, acute life events, parental stressors, and chronic stressful situations, either as a result of environmental situations or from the child's own condition.

Axis VI – Global Assessment of Psychosocial Functioning ;
Functioning is rated on a scale of 0-8.

Care needs of children with an Axis I clinical psychiatric syndrome can vary from child to child depending on the multiplicity of other problems present, e.g. a child with ADHD and a normal IQ, with no specific learning difficulties, good medical health and a stable environment may have very different care needs to a child with low IQ, perhaps a specific reading problem, coincidental medical conditions e.g. recurrent asthma, diabetes etc. and perhaps comes from a single parent family.

Ref; World Health Organization, 1996.
Cambridge University Press.

Appendix 8

DELETED (May 2013)

Conditions which are **more likely** to result in a disability so severe that the child requires continual or continuous care and attention substantially in excess of the care and attention normally required by a child of the same age

Diagnostic Category	ICD 10 Code
Infectious and Parasitic Diseases	
Human immunodeficiency virus [HIV] disease	B20-B24
Neoplasms	
Malignant Neoplasms	C00-C97
Disease of the Blood and blood forming organs and certain disorders involving the Immune Mechanism	
Sickle Cell anaemia	D57
Aplastic anaemias	D60-D61
Endocrine, Nutritional and Metabolic Diseases	
Insulin Dependent Diabetes Mellitus	E10
Cystic Fibrosis	E84
Mental and Behavioural Disorders	
Mental Retardation	F71-F73
Diseases of the Nervous System	
Systemic atrophies primarily affecting the CNS	G10-G13
Muscular Dystrophy	G71
Cerebral Palsy and other paralytic syndromes	G80-G83
Hydrocephalus	G91
Diseases of the Eye and Adnexa	
Blindness, both eyes	H54.0
Diseases of the Ear and Mastoid Process	
Conductive and sensorineural hearing loss	H90
Diseases of the Genitourinary System	
Renal Failure	N17-N19
Congenital malformations, deformations and chromosomal abnormalities	
Congenital malformations of the central nervous system	Q01-Q07
Chromosomal abnormalities, not elsewhere classified	Q90-Q99 (excl Q96)

Conditions which are **less likely** to result in a disability so severe that the child requires continual or continuous care and attention substantially in excess of the care and attention normally required by a child of the same age.

Diagnostic Category	ICD 10 Code
Infectious and Parasitic Diseases	
Certain Infectious and Parasitic Diseases	A00-B99 (excl B20-B24)
Neoplasms	
Benign Neoplasms	D10-D36
Disease of the Blood and blood forming organs and certain disorders involving the immune Mechanism	
Haemolytic anaemias	D55-D59 (excl D57)
Other anaemias	D62-D64
Coagulation Defects, purpura and other haemorrhagic conditions	D65-D69
Other disease of the blood and blood forming organs	D70-D77
Certain disorders involving the immune mechanism	D80-D89
Endocrine, Nutritional and Metabolic Diseases	
Disorders of the thyroid gland	E00- E07
Non Insullin Dependent Diabetes Mellitus	E11-E14
Disorders of other endocrine glands	E20-E35
Metabolic Disorders (excl Cystic Fibrosis)	E70-E90 (excl E84)
Mental and Behavioural Disorders	
Mood (Affective) Disorders	F30-F39
Neurotic, stress related and somatoform disorders	F40-F48
Behavioural syndromes associated with physiological disturbances and physical factors	F50-F59
Mental Retardation	F70-F79 (Excl F71-F73)
Disorders of Psychological Development	F80-F89
Behavioural and emotional disorders with onset usually occurring in Childhood and adolescents	F90-F98
Diseases of the Nervous System	
Inflammatory diseases of the central nervous system	G00-G09
Epilepsy	G40
Nerve, nerve root and plexus disorders	G50-G59
Diseases of the Eye and Adnexa	
Diseases of the eye and adnexa	H00-H59 (excl H54.0)
Diseases of the Ear and Mastoid process	
Diseases of the Ear and Mastoid process	H60-H95 (excl H90)

Diseases of the Respiratory system	
Asthma	J45
Bronchiectasis	J47
Diseases of the Digestive System	
Non infective enteritis / Colitis	K50-K52
Diseases of the Skin and Subcutaneous System	
Dermatitis and Eczema	L20-L30
Papulosquamous disorders	L40-L45
Diseases of the Musculo skeletal system and connective tissue	
Inflammatory Polyarthropathies	M05-M14
Systemic connective tissue disorders	M30-M36
Congenital malformations, deformations and chromosomal abnormalities	
Congenital malformations of the eye, ear, face & neck	Q10-Q18
Congenital malformations of the circulatory system	Q20-Q28
Congenital malformations of the respiratory system	Q30-Q34
Cleft lip and palate	Q35-Q37
Congenital malformations of the digestive system	Q38-Q45
Congenital malformations of the genital organs	Q50-Q56
Congenital malformations of the urinary system	Q60-Q64
Congenital malformations and deformations of the musculoskeletal system	Q65- Q79
Other congenital malformations	Q80-Q89
Turner's syndrome	Q96
Factors influencing health status and contact with health services	
Asymptomatic human immunodeficiency virus [HIV] infection status	Z21

Appendix 9

5 Main Headings for "Good Cause" for making a late Claim

1. Lack of knowledge by itself is not regarded as a sufficient reason for not claiming in time. The Deciding Officer must consider what is a reasonable level of knowledge to be expected in the particular case. If, for example, legislation extends entitlement to a particular scheme a plea of ignorance of the change may be reasonable.

2. Where the failure to claim within the prescribed time arose as a result of information supplied by staff of the Department to the person concerned or to his/her appointed agent, the claim may be backdated to the date of commencement of entitlement if subsequent to the date the information was given or (if entitlement already existed) the date on which that information was given plus any period in respect of which a disqualification would not have been imposed if the claim had been made on that date.

3. Where the delay arose because the person was incapacitated by illness or infirmity between the date of initial entitlement and the date of claim, a back-date may be considered. The nature of the illness or incapacity must be such that the claimant could not have been expected to make a claim or appoint an agent to act on his/her behalf.

4. A 'force majeure' means events or actions which by their nature were so intense as to render it impossible for a claimant to satisfy the requirement of making a claim.

5. A claim may also be backdated where payment is necessary to prevent or relieve financial hardship.