Social Welfare Services
CSG 1

Data Classification R

Application form for

Carer's Support Grant

You need a Personal Public Service Number (PPS No.) before you apply.

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.
- Please do not strikethrough any of the boxes. Leave boxes blank if they do not apply to you.

- You as the carer should sign the Declaration in **Part 1** after you complete the form.
- The person you are caring for must sign the Authorisation in **Part 5**.
- The doctor of the person receiving care from you must also sign **Part 5**.

Fill in **Parts 1** to **3** as they apply to you. The person you are caring for should sign **Part 5** confirming that they require care. You should then get the doctor to complete the medical report. When the form is completed, sign declaration in **Part 1**.

Complete a form **CSG 1** for each individual you are caring for.

If you need any help to complete this form, please contact your local Citizen Information Centre, your local Intreo Centre or your local Social Welfare Office or the Carer's Support Grant Section at (01) 673 2222.

For more information, log on to **www.welfare.ie**.

How to fill 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. [X] Ms. [ ] Other [ ]
3. Surname:	M U R P H Y
4. First name(s):	M A U R E E N
5. Your first name as it appears on your birth certificate:	M A R Y
6. Birth surname:	M C D E R M O T T
7. Your date of birth:	2 8 / 0 2 / 1 9 7 0 (D D M M Y Y Y Y)
8. Your mother's birth surname:	K E L L Y

Contact Details

9. Your address:	1 NEW STREET
	OLD TOWN
	DONEGAL TOWN
County	DONEGAL — Postcode
10. Your telephone number:	ONE NUMBER PER BOX (MOBILE)
	ONE NUMBER PER BOX (LANDLINE)
11. Your email address:	ONE CHARACTER PER
	BOX

SAMPLE

Application form for
Carer's Support Grant

Social Welfare Services
CSG 1

Data Classification R

Part 1 Your own details (Carer's 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 date of birth:** D D M M Y Y Y Y
8. **Your mother's birth surname:**

Contact Details

9. **Your address:**

County Postcode

10. **Your telephone number:** MOBILE

LANDLINE

11. **Your email address:**

Declaration

I declare that the information given by me on this form is truthful and complete. I understand that if any of the information I provide is untrue or misleading or if I fail to disclose any relevant information, that I will be required to repay any payment I receive from the Department and that I may be prosecuted. I undertake to immediately advise the Department of any change in my circumstances which may affect my continued entitlement.
If you cannot sign your name, make a mark, such as an X and have it witnessed.

Signature (**not** block letters) Date: D D M M 2 0 Y Y

Signature of witness (**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 1 continued — Your own details

12. What country were you born in?

13. Are you?

- Single
- Married
- Separated
- Divorced
- Widowed
- Cohabiting
- In a Civil Partnership
- A surviving Civil Partner
- A former Civil Partner (you were in a Civil Partnership that has since been dissolved)

14. Are you getting any of the following:

Carer's Allowance?	Yes	No
Carer's Benefit?	Yes	No
Domiciliary Care Allowance?	Yes	No

If you were getting one of these three payments on the 1st Thursday in June of the year in question, you do not have to complete this form, you will get the Grant automatically for that year. Only one grant is paid for each person receiving full time care and attention.

If 'No', please state:

Have you ever applied for Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance?

Yes No

If 'Yes', please state:

What year did you apply? Y Y Y Y

15. Are you, or have you been, employed or self-employed (includes farming) outside the home in the last 18 months?

Yes No

If 'Yes', please state:

Your occupation:

Periods of employment and how many hours worked each week:

Period of employment 1

From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Hours: a week

Period of employment 2

From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Hours: a week

Part 1 continued — Your own details

16. Are you attending or have you attended an Educational or training course outside the home in the last 18 months?

☐ Yes ☐ No

If 'Yes', please state:

Course attended: ☐ Vocational Training Opportunities Scheme (VTOS) ☐ FÁS/SOLAS Training

If other, please specify: ____________________

Hours: ____ a week

17. If you work(ed) or attend(ed) an educational or training course outside the home for 15 hours or less a week in the last 18 months please have the following completed by your employer or training authority.

To be completed by Employer or Training Authority

I certify that ____________________ is/was

employed by or in training with me for ____ hours a week since __ __ (D D) __ __ (M M) __ __ __ __ (Y Y Y Y)

Location of employment: ____________________

Employment or training ceased (if applicable) __ __ (D D) __ __ (M M) __ __ __ __ (Y Y Y Y)

Employer or Training Authority Details

Name: ____________________

Address: ____________________

County ____________ Post Code ____________

Telephone Number: ____________ MOBILE

____________ LANDLINE

I declare that the information given here is true and complete.
Signed by or on behalf of the Employer or Training Authority:

Signature (**not** block letters)

Date: __ __ (D D) __ __ (M M) 2 0 __ __ (Y Y Y Y)

Official stamp

It is an offence not to provide relevant information about a claim for Carer's Support Grant or to take part in a false application.

Part 2 — Your payment details

Please choose one payment option below.

NOTE: You must have a Social Welfare or Public Services Card to collect your payment at a Post Office.

Financial Institution

You will find the following details printed on statements from your financial institution.

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Post Office

Post Office address:

Part 3 — Details of person you are caring for

18. Their PPS No.:

19. Their surname:

20. Their first name(s):

21. Their date of birth: D D M M Y Y Y Y

22. Is anyone else getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance for them?

☐ Yes ☐ No

Only one Grant is paid for each person needing full-time care and attention.

23. What is your connection to the person being cared for?

24. Has anyone else applied for the Respite Care Grant or the Carer's Support Grant for the person named in Q19 and Q20?

☐ Yes ☐ No

If 'Yes', please state:

What year did they last apply? Y Y Y Y

Part 3 continued — Details of person you are caring for

25. Has the person being cared for worked outside the home in the last 18 months?

☐ Yes ☐ No

If 'Yes', please state:

Employer's name:

Address:

County — Post Code

Type of work:

Hours: a day

Days: a week

26. In the past 18 months had this person any overnight stays in a Hospital/Convalescent home or similar type of institution?

☐ Yes ☐ No

If 'Yes', please state:

Hospital/Home name:

Address:

County — Post Code

Date spent here: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

27. When did you start providing full-time care for them?

D D M M Y Y Y Y

28. Have you been or are you likely to be providing full-time care and attention for at least 6 months?

☐ Yes ☐ No

IMPORTANT: Carer's Support Grant is paid only where the 6 month period of care includes the first Thursday in June. For more information, log on to www.welfare.ie.

Details of person you are caring for

29. Please specify the daily duties (including personal care and supervision) YOU perform in looking after this person:

Hours: ☐☐ a day

Days: ☐ a week

30. If they don't live with you please state their address:

County

Post Code

The distance between the households: ☐☐ kilometres

Is the above address a full-time residential care facility (for example, Nursing Home)?

☐ Yes ☐ No

31. Is there a direct phoneline or electronic means of communication between the households?

☐ Yes ☐ No

MOBILE

LANDLINE

If 'No', please give details of other direct link:

32. Is anyone else living at the address of the person you are caring for?

☐ Yes ☐ No

If 'Yes', please state:

Surname of person:

First name(s):

Their relationship to the person you are caring for:

Note: A separate sheet of paper can be used for more details if needed.

Part 4 Check if you qualify for Carer's Support Grant

Are you working more than 15 hours per week outside the home?

☐ Yes ☐ No

Are you getting Jobseeker's Benefit or Jobseeker's Allowance?

☐ Yes ☐ No

Are you signing for credited contributions?

☐ Yes ☐ No

If you answered 'Yes' to any of the above, you are not eligible for the Carer's Support Grant. Please do not proceed with this claim.

Are you looking after the person(s) named in this form on a full-time basis?

☐ Yes ☐ No

Have you been or will you be providing full-time care and attention for at least 6 months?

☐ Yes ☐ No

The grant is only payable where the period of care includes the first Thursday in June.

If you answered 'No' to either of the above, you are not eligible for the Carer's Support Grant. Please do not proceed with this claim.

To proceed with this application

- **Check you have given your PPS Number**
- **Check you have answered all the questions**
- **Check you have given the PPS Number of the person you are caring for**
- **Check you have signed the form (Part 1)**
- **Have the medical report (Part 5) signed by the person you are caring for and completed by their doctor.**

IMPORTANT! If any information is missing it will delay your application.
Failure to answer any questions could cause a delay in your application

Send this completed application form to:

Carer's Support Grant Section
Department of Social Protection
PO Box 10085
Dublin 2

Telephone: (01) 673 2222

Data Protection Statement

The Department of Social Protection will treat all information and personal data you give us as confidential. However, it should be noted that information may be exchanged with other Government Departments / Agencies in accordance with the law.

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

Note to carer

Remember!

You do **not** need to apply for the Carer's Support Grant if on the first Thursday in June of the year, in respect of which you are claiming, you or anyone else, is getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance for caring for this person.

The Carer's Support Grant is paid automatically to anyone in these circumstances.

The following medical report is in two parts. **Have Section 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 Section B, questions 1-11 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.

Medical Report for

Carer's Support Grant

Social Welfare Services

Med Rpt CSG1

Data Classification R

Part 5 Medical Report

Section A

Applicant details (details of person providing full-time care)

Surname: | | | | | | | | | | | | | | | | | | | |

First name: | | | | | | | | | | | | | | | | | | | |

PPS No.: | | | | | | | | | |

Declaration by person receiving full-time care and attention

Section A

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 Protection if this changes.

I permit my doctor to provide you, the Department of Social Protection, with medical information that you may need for this application for Carer's Support Grant.

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 Support Grant scheme may be reviewed at any time.

Signature (**not** block letters) of the person receiving care

Date: D D M M 2 0 Y Y

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 (**not** block letters)

Date: D D M M 2 0 Y Y

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 Support Grant 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.

Section B

Section B

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess if they qualify for care under the Carer's Support Grant scheme, please complete the medical report across. 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 fully completing and returning this report. To ensure payment please enter your DSP 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.

If you have any queries, please contact the **Carer's Support Grant Section** at (01) 673 2222

Note:

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

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 SUPPORT GRANT SECTION.

Medical Report

Section B

1. Patient details **(please use Block capitals)**

Surname:

First name:

Address:

Date of birth: D D M M Y Y Y Y

PPS No.:

Mobile telephone No.:

The patient may be contacted by text message in relation to a medical assessment.

Occupation:

2(a). Your patient since: D D M M Y Y Y Y

2(b). How often does the patient visit your surgery?

- [ ] Weekly
- [ ] Monthly
- [ ] Less often

3. Diagnosis(es) (use BLOCK CAPITALS):

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 3 months
- [ ] 3-6 months
- [ ] 6-12 months
- [ ] 12-24 months
- [ ] indefinitely

7. Please give:

Medical history

Surgical/Obstetrical history

Attach relevant reports/test results/referrals

Hospital admissions

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

Relevant investigations

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

Attending a specialist

On medication

Other treatment

Clinical findings

9. Pregnant: ☐ Yes ☐ No

If 'Yes', give EDD: D D M M Y Y Y Y

Please attach any relevant reports/results of investigations.

Additional Information:

ABILITY/DISABILITY PROFILE:

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

	Normal	Mild	Moderate	Severe	Profound
Mental Health/Behaviour →	☐	☐	☐	☐	☐
Learning/Intelligence →	☐	☐	☐	☐	☐
Consciousness/Seizures →	☐	☐	☐	☐	☐
Balance/Co-ordination →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Manual Dexterity →	☐	☐	☐	☐	☐
Lifting/Carrying →	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting →	☐	☐	☐	☐	☐
Sitting/Rising →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing Stairs/Ladders →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

11. A Medical Assessment by one of the Department's Medical Assessors may be required to determine eligibility.

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

If 'No', give details here:

Doctor's name:

DSP panel number:

IMC number:

Address:

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

Date: DD MM 20YY

Doctor's official stamp

For Official use Only

(i) **Eligible for Carer's Support Grant:** ☐

(ii) **Review:** ____________________

(iii) **DNRA:** ☐

(iv) **Not eligible for Carer's Support Grant:** ☐

Give reasons:

Signed ______________________________ **Medical Assessor**

Date: D D M M 2 0 Y Y

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