How to complete this application form.

You should only complete this form if you have completed a Carer’s Benefit application form (CARB 1) and are claiming Carer’s Benefit for additional person(s).

• Please use this page 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.
• You need a Personal Public Service Number (PPS No.) before you apply

**Carer:**

Please complete this form for each additional person(s) you are caring for and attach it to the application form **CARB 1**. Please fill in all details in **Parts 1** and **2**. The person you are caring for should sign **Section A** in **Part 3** confirming that they require care.

**Doctor:**

Please fill in **Section B** in **Part 3** of the medical report. Please make sure you sign and stamp this part of the form.

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**.

You should apply for Carer’s Benefit as soon as you start caring for someone. You could lose payment if you don’t.
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: 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

Contact Details

9. Your address: 1 NEW STREET
   OLD TOWN
   CODONEGAL

10. Your telephone number: 0 8 6 1 2 3 4 5 6 7
    MOBILE
    0 1 7 0 4 3 0 0 0
    LANDLINE

11. Your email address: MURPHY@WELFARE.IE
Application form for Carer’s Benefit for additional person(s)

**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:
   - DD MM YYYY

**Contact Details**

9. Your address:
   - [ ]

10. Your telephone number:
    - MOBILE
    - LANDLINE

11. Your email address:
    - [ ]

**Declaration**

I declare that all the information I have given on this form is accurate.
I will tell the Department when my means or circumstances change.

Signature (not block letters)

Date: DD MM YYYY

**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 person you are caring for

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Their PPS No.:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Title: (insert an ‘X’ or specify)</td>
<td>Mr.</td>
<td>Mrs.</td>
<td>Ms.</td>
</tr>
<tr>
<td>14. Their surname:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Their first name(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Their birth surname:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Their date of birth:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Their address:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Their mother’s birth surname:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. What is your relationship to the person you are caring for?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21(a). Date you started caring for this person:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(b). Has anyone paid you to look after this person since this date?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>22. Are they getting Domiciliary Care Allowance?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>23. If ‘No’, have you or anyone applied for Domiciliary Care Allowance for them?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>24. What other type of payment are they getting, if any?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

25. Is the person named above attending a day care or rehabilitative centre? Yes No

26. Do they stay overnight in any of these centres? Yes No

*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.*
27. If the person stays overnight at a care facility or centre, please state:

Name of centre: 
Address of centre: 
Telephone number of centre: 

Number of hours they attend: [ ] a day  
Number of days they attend: [ ] a week

Please attach letter of confirmation from day care centre.

28. Does the person you are caring for live with you?

[ ] Yes    [ ] No

If 'No', please state:
Number of hours you will be providing care while on Carer's Leave: [ ] a day
Number of days you will be providing care while on Carer's Leave: [ ] a week

Does anyone else live with the person you are caring for?
[ ] Yes    [ ] No

If ‘Yes’, please give details in the space provided.

The Distance between the households: [ ] Kilometres

Is there a direct phoneline between the households?
[ ] Yes    [ ] No

If ‘No’, please give details of other direct link in the space provided.

Details of daily duties you perform looking after this person:

Note
Please answer the above question fully if the person you are caring for does not live with you.
Note to carer

Important

You do not need to send a medical report at this stage for a child for whom Domiciliary Care Allowance is being paid by this Department.

The following medical forms are in two parts. **Have Section A completed and signed by the person 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.
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.

Section A

Applicant details (details of person providing full-time care)
Surname: 
First name: 
PPS No.: 

Date: 

Signature (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.

Date: 

Signature (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.
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 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 Benefit Section at LoCall: 1890 92 77 70.

Note:
The carer should already have filled Parts 1 and 2 of the application form. The person(s) 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 BENEFIT SECTION.
1. Patient details
   Surname: 
   First name: 
   Address: 
   Date of birth: 
   PPS No.: 
   Mobile telephone No.: 

2. Your patient since: 

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

4. ICD10 Code(s):

5. Date condition started:

6. How long do you expect this condition to continue?
   - less than 3 months
   - 3-6 months
   - 6-12 months
   - 12-24 months
   - indefinitely

The patient may be contacted by text message in relation to a medical assessment.
### Part 3 continued

#### Medical Report

7. Please give:

   Medical history

   Surgical/Obstetrical history

   Hospital admissions

   Date of discharge: [ ] [ ] [ ] [ ]

   Result of relevant investigations

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

   Attending a specialist

   On medication

   Other treatment

9. Pregnant:  

   Yes  [ ]  No  [ ]

   If ‘Yes’, give EDD: [ ] [ ] [ ] [ ]

Please attach any relevant reports/results of investigations.

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

<table>
<thead>
<tr>
<th>Area</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health/Behaviour</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Learning/Intelligence</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Consciousness/Seizures</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Balance/Co-ordination</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Vision</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Hearing</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Speech</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Continence</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Reaching</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Manual Dexterity</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Lifting/Carrying</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Bending/Kneeling/Squatting</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Sitting/Rising</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Standing</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Climbing Stairs/Ladders</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
<tr>
<td>Walking</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
<td>❌</td>
</tr>
</tbody>
</table>

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: 202
(i) Eligible for Carer’s Benefit: 

(ii) Review: 

(iii) DNRA: 

(iv) Not eligible for Carer’s Benefit: 

Give reasons: 

Signed ________________________________ Medical Assessor 

Date:  

D D M M Y Y Y Y