



# Application form for Homemaker's Scheme

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

## **How to complete this application form.**

- Please use this page as a guide to filling in this form.
- Please answer **all questions**. Incomplete forms will be returned and this may delay your application.
- Please use **BLACK** ball point pen.
- Please use **BLOCK LETTERS** and place an X in the relevant boxes.

### **Important**

**If you are/were getting Child Benefit, Carer's Benefit, Carer's Allowance or Carer's Support Grant (formerly known as Respite Care Grant) from this Department you do not need to complete this form as you have an automatic entitlement to the Homemaker's Scheme.**

Fill in all parts of the form as they apply to you. When the form is completed, read **Part 7** and sign the declaration in **Part 1**.

### **Person being cared for:**

The person you are (or were) caring for should sign **Part 6** confirming that they require or required care.

### **Doctor:**

Please fill in **Part 8** of the form. 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 Citizens Information Centre, your local Intreo Centre or your local Social Welfare Office.

For more information, log on to **[www.welfare.ie](http://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.	<input type="checkbox"/>	Mrs.	<input checked="" type="checkbox"/>	Ms.	<input type="checkbox"/>	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		N	E	W		S	T	R	E	E	T										
	O	L	D				T	O	W	N												
	D	O	N	E	G	A	L				T	O	W	N								
County	D	O	N	E	G	A	L				Postcode											
10. Your telephone number:	O	N	E				N	U	M	B	E	R				P	E	R		B	O	X
	O	N	E				N	U	M	B	E	R				P	E	R		B	O	X
11. Your email address:	O	N	E				C	H	A	R	A	C	T	E	R		P	E	R			
	B	O	X																			

# SAMPLE



## Part 1 continued

## Your own details

12. What country were you born in?

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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. If you are married, in a civil partnership or cohabiting, from what date?

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D D

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M M

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Y Y Y Y

## Part 2

## Your work and claim details

If you are/were in receipt of Child Benefit, you are automatically entitled to the Homemaker's Scheme for qualified children (under age 12).

15. Are/were you getting Child Benefit from this Department for the child(ren) in your care?

Yes

No

If 'No', is the Child Benefit being paid to another person?

Yes

No

If 'Yes', how is this person related to you?

Spouse (your husband or wife)

Cohabitant (a man or woman you live with but are not married to)

Guardian of child(ren)

Grandparent of child(ren)

Other, state relationship here, for example, aunt, sister

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16. Are you getting Carer's Allowance or Carer's Benefit?

Yes

No

If 'No', have you ever applied for Carer's Allowance or Carer's Benefit?

Yes

No

If 'Yes', what year did you apply?

Y	Y	Y	Y
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17. Have you ever applied for Carer's Support Grant (formerly known as Respite Care Grant)?

Yes

No

If 'Yes', what year did you apply?

Y	Y	Y	Y
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18. Are/were you getting Jobseeker's Allowance or Jobseeker's Benefit?

Yes  No

19. Are/were you signing for Jobseeker's Benefit Credits?

Yes  No

20. Are you employed at present?

Yes  No

If 'Yes', please state:

Employer's name:


Employer's address:


Gross weekly earnings:

€  ,  .  a week

Please attach 3 of your most recent payslips or P60.

'Gross pay' is your pay before any deductions, such as tax, PRSI or union dues.

If 'No', please state:

When you last worked:

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
D D	M M	Y Y Y Y

Please attach your P45

Employer's name:


Employer's address:


21. Are you self-employed at present?

Yes  No

You are 'self-employed' if you work for yourself.

If 'Yes', please state:

Gross yearly earnings: €  ,  .  a year

Please attach a statement from your accountant.

'Gross pay' is your pay before any deductions, such as tax, PRSI or union dues.

Part 2 continued

Your work and claim details

If 'No', when did you last work as self-employed?

DD MM YYYY

Please attach a statement from your accountant to confirm this date.

22.If you are employed or self-employed, do you intend to give up this work to provide full-time care and attention for the person or people named in Part 5?

Yes No

If 'Yes', when will you give up this work?

DD MM YYYY

Please attach a letter from your employer or a statement from your accountant if you are self-employed to confirm this date.

23.Are/were you attending an educational or training course outside the home?

Yes No

If 'Yes', how many hours do/did you attend?

Week

Type of course:

VTOS FAS Training

Other:

Other field

Please specify

Part 3

Your spouse's, civil partner's or cohabitant's details

24.Their PPS No.:

PPS No. field

25.Title: (insert an 'X' or specify)

Mr. Mrs. Ms. Other

26.Their surname:

Surname field

27.Their first name(s):

First name field

28.Their birth surname:

Birth surname field

29.Their date of birth:

DD MM YYYY

30.Their mother's birth surname:

Mother's birth surname field

31.Their address:

Only answer this question if you are married or in a civil partnership and do not live together.

Address field

You should complete this section if you are/were providing fulltime care to a child(ren) aged under 12 and you are/were not getting Child Benefit for them.

32. How many children do you wish to claim for?

 

Under age 12

Please state child's:

**Child 1**

Surname:

                    

First name(s):

                    

PPS No.:

         

Date of birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Are they living with you?

 Yes  No

Date caring started:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Is caring ongoing?

 Yes  No

Date caring finished:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Reason caring finished:

**Child 2**

Surname:

                    

First name(s):

                    

PPS No.:

         

Date of birth:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Are they living with you?

 Yes  No

Date caring started:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Is caring ongoing?

 Yes  No

Date caring finished:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

Reason caring finished:

**Child 3**

Surname:

First name(s):

PPS No.:

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

Are they living with you?  Yes  No

Date caring started:        
D D M M Y Y Y Y

Is caring ongoing?  Yes  No

Date caring finished:        
D D M M Y Y Y Y

Reason caring finished:

**Child 4**

Surname:

First name(s):

PPS No.:

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

Are they living with you?  Yes  No

Date caring started:        
D D M M Y Y Y Y

Is caring ongoing?  Yes  No

Date caring finished:        
D D M M Y Y Y Y

Reason caring finished:



You should complete this section if you are/were providing fulltime care to an ill or incapacitated person aged 12 or over.

Please give details of all members of your household who need or needed full-time care and attention as follows:

List people here for whom you give or have given full-time care and attention (including adults or children over age 12 who are incapacitated).

Please state:

33. Their PPS No.: [grid]

34. Title: (insert an 'X' or specify) Mr. [ ] Mrs. [ ] Ms. [ ] Other [grid]

35. Their surname: [grid]

36. Their first name(s): [grid]

37. Their birth surname: [grid]

38. Their date of birth: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
D D M M Y Y Y Y

39. Their mother's birth surname: [grid]

40. Their address: [grid]  
During caring period. [grid]  
[grid]  
[grid]

41. What is your relationship to this person? [grid]

42. What date did caring start? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
D D M M Y Y Y Y

43. Is care ongoing? [ ] Yes [ ] No

44. What date did caring cease? [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  
D D M M Y Y Y Y

Reason caring finished: [grid]

45. Do/did they live with you?  Yes  No

If 'No', please state:

Number of hours you provide(d) care:  a day

Number of days you provide(d) care:  a week

Does/did 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 communication link between the households (ie landline, mobile phone or Community Alert alarm)?

Yes  No

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

Details of daily duties you perform(ed) looking after this person:



53. If the person stays/stayed overnight at a care facility or centre, please state:

Name of centre:


Address of centre:


Telephone number of centre:

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LANDLINE

Number of days they attend:  a week

Number of nights they attend:  a week

Please attach letter of confirmation from day care centre.

**Note:** A separate sheet of paper can be used if you are caring (have cared) for more than one person.

Part 6

Declaration by person who is receiving or received full-time care and attention

The person who is getting or who has received full-time care and attention as listed in **Part 5** must fill in this part but only if they are aged 12 or over.

**Note:** Children under age 12 do not have to complete this part.

I declare that I need or needed full-time care and attention for the period stated in **Part 5** and that the person named in **Part 1** is providing full-time care and attention for me. I will tell the Department of Social Protection if this changes.

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Signature (not block letters) of the person receiving care

Date: 

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D D M M Y Y Y Y

If you cannot sign, make a mark and have it witnessed. The witness should sign below.

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Signature (not block letters)

Date: 

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D D M M Y Y Y Y

**Have you enclosed the following?**

- **Your birth certificate** (if born outside the Republic of Ireland)
- **Birth certificates for all people you were or are providing with full-time care** (if born outside the Republic of Ireland)
- **Letter from your employer, if you intend to leave your job to provide full-time care and attention, to confirm the date you will leave work**
- **A recent payslip or P60 if you are working**
- **A P45 if you have ceased working**
- **A statement from your accountant if you are self-employed or if you have ceased self-employment**
- **Confirmation of receipt or award of Domiciliary Care Allowance.**

**Original certificates only. We do not accept photocopies.**

**If your form is not fully complete or the documents required are not enclosed there will be a delay in deciding your claim for the Homemaker's Scheme.**

## **Please remember to sign the Declaration in Part 1.**

**If you have any difficulty in filling in this form, please contact your local Citizens Information Centre, your local Intreo Centre or your local Social Welfare Office.**

Send this completed application form to:

**Homemaker's Section**

Department of Social Protection  
McCarter's Road  
Buncrana  
Co. Donegal

Telephone: (01) 471 5898

LoCall: 1890 690 690

If you are calling from outside the Republic of Ireland please call + 353 1 471 5898

**Note**

**The rates charged for using 1890 (LoCall) numbers may vary among different service providers.**

**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.

A Doctor, for people who are/were medically, mentally or physically incapacitated, must complete this part. Please note the doctor must complete all parts including (a) and (b) below.

I certify that:

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is/was suffering from:

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Does/did the above named person require:

a) full-time supervision in order to avoid danger to themselves?

Yes       No

and

b) full-time supervision and frequent assistance throughout the day in connection with their normal personal needs?

Yes       No

Please state duration of their incapacity:

From: 

D	D
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M	M
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Y	Y	Y	Y
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To: 

D	D
---	---

M	M
---	---

Y	Y	Y	Y
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Additional Information:

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Doctor's name:

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DSP panel number:

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IMC number:

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Address:

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Doctor's Signature (not block letters)

--	--

D D

--	--

M M

2	0		
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Y Y Y Y

Doctor's official stamp

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