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](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. [ ] 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
8. Your mother’s birth surname: K E L L Y

Contact Details

Count Postcode

M O B I L E O N E N U M B E R P E R B O X
L A N D L I N E

Application form for Carer’s Support Grant

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: 

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: 

Signature of witness (not block letters)

Date: 

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?
- Carer’s Benefit?
- Domiciliary Care Allowance?

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?

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: DD MM YY YY YY

To: DD MM YY YY YY

Hours: ____ a week

**Period of employment 2**

From: DD MM YY YY YY

To: DD MM YY YY YY

Hours: ____ a week
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: 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 Y Y Y Y

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.

<table>
<thead>
<tr>
<th>Details</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of financial institution:</td>
<td>Building Address</td>
</tr>
<tr>
<td>Bank Identifier Code (BIC):</td>
<td>Building Address</td>
</tr>
<tr>
<td>International Bank Account</td>
<td>Building Address</td>
</tr>
<tr>
<td>Number (IBAN):</td>
<td>Building Address</td>
</tr>
<tr>
<td>Name(s) of account holder(s):</td>
<td>Building Address</td>
</tr>
<tr>
<td>Name 1:</td>
<td>Building Address</td>
</tr>
<tr>
<td>Name 2 (if any):</td>
<td>Building Address</td>
</tr>
</tbody>
</table>

**Post Office**

<table>
<thead>
<tr>
<th>Details</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post Office address:</td>
<td>Building Address</td>
</tr>
<tr>
<td></td>
<td>Building Address</td>
</tr>
<tr>
<td></td>
<td>Building Address</td>
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<tr>
<td></td>
<td>Building Address</td>
</tr>
<tr>
<td></td>
<td>Building Address</td>
</tr>
</tbody>
</table>

### 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
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 M Y Y Y Y
   To: D M Y Y Y Y

27. When did you start providing full-time care for them?
   D 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.
29. Please specify the daily duties (including personal care and supervision) **YOU** perform in looking after this person:

<table>
<thead>
<tr>
<th>Hours:</th>
<th>a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Days:</td>
<td>a week</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>County</th>
<th>Post Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

The distance between the households: ___________ kilometres

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td></td>
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</table>

If ‘No’, please give details of other direct link:

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<thead>
<tr>
<th>MOBILE</th>
<th>LANDLINE</th>
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</table>

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

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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</table>

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

Personal data is required to determine eligibility for payments and services, administered for Ireland’s social protection system. It may be shared with other Government Departments/Agencies where provided for by law. Data protection policy available at www.welfare.ie/dataprotection or hard copy.

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.
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: __ __ MM YY

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: __ __ MM YY

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

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.
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<tr>
<td><strong>1. Patient details</strong></td>
<td>(please use Block capitals)</td>
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<tr>
<td>Surname:</td>
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<tr>
<td>First name:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>Date of birth:</td>
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<tr>
<td>PPS No.:</td>
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<tr>
<td>Mobile telephone No.:</td>
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The patient may be contacted by text message in relation to a medical assessment.

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<tr>
<td><strong>2(a). Your patient since:</strong></td>
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<td>D D M M Y Y Y Y</td>
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<td><strong>2(b). How often does the patient visit your surgery?</strong></td>
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<tr>
<td>□ Weekly</td>
<td>□ Monthly</td>
<td>□ Less often</td>
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<td><strong>3. Diagnosis(es)</strong></td>
<td>(use BLOCK CAPITALS)</td>
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<td><strong>4. ICD10 Code(s):</strong></td>
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<td><strong>5. Date condition started:</strong></td>
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<td>D D M M Y Y Y Y</td>
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<td><strong>6. How long do you expect this condition to continue?</strong></td>
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<tr>
<td>□ less than 3 months</td>
<td>□ 3-6 months</td>
<td>□ 6-12 months</td>
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<tr>
<td>□ 12-24 months</td>
<td>□ indefinitely</td>
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<tbody>
<tr>
<td><strong>7. Please give:</strong></td>
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<td></td>
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<tr>
<td>Medical history</td>
<td></td>
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</tr>
</tbody>
</table>

Surgical/Obstetrical history

Attach relevant reports/test results/referrals
Part 5 continued

Medical Report

Hospital admissions

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:

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

[Blank space for details]

Doctor’s name: [Blank space for name]
DSP panel number: [Blank space for number]  IMC number: [Blank space for number]
Address: [Blank space for address]

[Blank space for doctor's signature]  
[Blank space for date: D D M M Y Y Y Y]  
[Blank space for doctor's official stamp]
(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: 20[

Data Protection Statement

Personal data is required to determine eligibility for payments and services, administered for Ireland’s social protection system. It may be shared with other Government Departments/Agencies where provided for by law. Data protection policy available at www.welfare.ie/dataprotection or hard copy.

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