Application form for

Domiciliary Care Allowance

Social Welfare Services
Dom Care 1

Data Classification R

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 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. If a question does not apply to you, please leave the answer area blank.

Applicant: Should complete **Parts 1** to **5.**

G.P./Specialist: The child's G.P./Specialist should complete **Parts 6** and **7.**

To qualify for Domiciliary Care Allowance the child must have a severe* disability that requires ongoing care and attention substantially* over and above the care and attention usually required by a child of the same age and is likely to last for at least one year and:

- Be aged under 16 (at 16, the child can apply for a Disability Allowance).
- Live at home with the person claiming the allowance for five or more days a week.
- Be ordinarily resident in the State. This means that the child has to live in the Republic of Ireland and only leaves Ireland for holidays.

In addition, the person claiming the allowance for the child must:

- Provide for the care of the child.
- Be habitually resident in the State. As above, the person claiming the payment must normally live in the Republic of Ireland.

Please let us know your mobile phone number and we will text you right away confirming that we received your application.

Note: If your child has a pervasive developmental disorder (PDD), e.g. Autism Spectrum Disorder, you may wish to have the medical professional or specialist dealing with your child complete an additional medical form **Dom Care 3** available on **www.welfare.ie**, from your local Intreo Centre, Social Welfare Office or Citizens Information Centre. The complete form will detail your child's conditions and any specific care needs the child might have as a result of their disability and will assist the Department's Medical Assessor in forming an opinion on eligibility.

If you need any help to complete this form, please contact your local Intreo Centre, Social Welfare Office or Citizens Information Centre.
For more information, log on to **www.welfare.ie**.

* The definitions used for terms such as severe or substantial in this qualifying condition are detailed in the DCA Medical Guidelines used by the Department is assessing applications for DCA. For more information, log onto **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. ☒ 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
D D M M Y Y Y Y

Contact Details

9. Your address:
1 NEW STREET
OLD TOWN
CO DONEGAL

10. Your telephone number: ONE NUMBER PER BOX
MOBILE
ONE NUMBER PER BOX
LANDLINE

11. Your email address: ONE CHARACTER PER BOX

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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:** D D M M Y Y Y Y

Contact Details

9. **Your address:**
10. **Your telephone number:** MOBILE / LANDLINE
11. **Your email address:**

Declaration

I declare that the child named in Part 2 resides with me and that all 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.

Signature (**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.

12345678

Part 2 Details of the child you are claiming for

12. **Child's PPS No.:**

13. **Child's Surname:**

14. **Child's First name(s):**

15. **Child's date of birth?**

D D M M Y Y Y Y

16. **Relationship to you:**

17. **Address (if different from yours):**

18. **Are you currently getting Child Benefit in respect of your child?**

☐ Yes ☐ No

19. **From what date has additional* care been required for your child?**

D D M M Y Y Y Y

***Additional means care substantially in excess of that normally needed by a child of this age.**

Domiciliary Care Allowance is normally paid from the month after you first apply.

If you did not make an application from the date the additional care was first required and wish to apply for backdating of the allowance, please state the reasons you delayed in applying:

20. **Does your child usually stay overnight in a special school/institution at any time during the year?**

☐ Yes ☐ No

If 'Yes', please state:

Name of school/institution:

Location/address:

Average number of nights per week they stay overnight in this school/institution:

☐ a week

Part 3 Your payment details

You can get your payment at a post office of your choice or direct to your current, deposit or savings account in a financial institution. An account must be in your name or jointly held by you. Please complete one option below.

Financial Institution

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

Name of financial institution:

Address of financial institution:

Sort code:

Account number:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Post Office

Please enter below the name and address of the post office where you wish to collect your payment.

Post office name and address:

Part 4 Please tell us about your child's care needs

This section allows you to tell us about the extra care your child needs compared with a child of the same age without the same disability. We understand that it might be hard to answer some of these questions but please give us as much information as you can in support of your application.
If you need more room feel free to use another sheet of paper. It will help us if you write the heading and number at the top of the page (for example: 4.1.1. Mobility). Don't forget to attach the page to this form and put your name and Personal Public Service Number (PPS No.) on the top of each page.

4.1.1 Mobility - compared to a child of the same age

Can your child walk and move around like other children of the same age?	☐ Yes	☐ No	☐ Does not apply
Can your child safely climb stairs without help?	☐ Yes	☐ No	☐ Does not apply

Does your child need to be lifted, or given assistance to be transferred to or from:

The bed	☐ Yes	☐ No	☐ Does not apply
A chair or wheelchair	☐ Yes	☐ No	☐ Does not apply
The toilet, bath or shower	☐ Yes	☐ No	☐ Does not apply

If your child has problems with mobility, please describe what help your child needs.

Does your child have any problem with balance or co-ordination?	☐ Yes	☐ No

If 'Yes', describe your child's difficulties. Is this all the time or sometimes? How do you help them?

4.1.2 Personal Care -

Tell us what help your child needs in each of the following areas compared to a child of the same age without their disability.

Can your child get out of bed safely on his/her own?	☐ Yes	☐ No	☐ Does not apply
Can your child dress him or herself?	☐ Yes	☐ No	☐ Does not apply
Can your child manage buttons and zips?	☐ Yes	☐ No	☐ Does not apply
Can your child wash their face, hands and teeth?	☐ Yes	☐ No	☐ Does not apply
Can your child shower or bath themselves without your help?	☐ Yes	☐ No	☐ Does not apply

If you answered No to any of the above, outline below the level of help your child needs for each area and how often you provide this each day.

Does your child need help to use the toilet?	☐ Yes	☐ No	☐ Does not apply
Does your child have any problems with wetting or soiling?	☐ Yes	☐ No	☐ Does not apply
Does your child need to wear nappies, pull ups or pads?	☐ Yes	☐ No	☐ Does not apply

If you answered Yes to any of these, please describe the difficulties your child has with toileting and how much help your child needs.

4.1.3 Feeding/Diet - compared to a child of the same age

Does your child need help or encouragement to eat or drink?	☐ Yes	☐ No
Does your child need a special diet?	☐ Yes	☐ No
Does he or she only eat certain food as a result of their disability?	☐ Yes	☐ No
Does your child have food allergies?	☐ Yes	☐ No
Do you have to control the food intake of your child?	☐ Yes	☐ No

If you answered Yes for any of the above, please describe your child's difficulties and the level of help they need.

4.1.4 Education/Schooling -

☐ Does not apply (not school age)

Does your child attend:

- **Preschool** ☐
- **Mainstream School** ☐
- **Home tuition/home schooling** ☐
- **Special Unit within Mainstream school** ☐
- **Special school for children with special needs** ☐

Does your child only attend school for part of the normal school day?	☐ Yes	☐ No
Has your child been excluded from any of the above as a result of their disability?	☐ Yes	☐ No
Does your child need extra help at school?	☐ Yes	☐ No
Does your child currently have access to a special needs assistant (SNA)?	☐ Yes	☐ No
Has your child ever been recommended for a special needs assistant (SNA) or had one in the past?	☐ Yes	☐ No
Has your child ever been recommended for assistive technology?	☐ Yes	☐ No
Does your child attend resource hours?	☐ Yes	☐ No
Does your child attend learning support?	☐ Yes	☐ No
Has your child had any issues at school that meant you had to attend?	☐ Yes	☐ No
Have you had to take your child home from school early on regular occasions for any reason?	☐ Yes	☐ No
Does your child have access to a visiting teacher for the visual or hearing impaired?	☐ Yes	☐ No

Please give details of the additional educational needs or supports your chid requires.

4.1.5 Sleeping - compared to a child of the same age

Does your child generally sleep well most nights? ☐ Yes ☐ No

If No give us details such as how many times your child wakes up during the night. How often does this happen? Is there anything you need to do for them?

4.1.5 Sleeping, support needs at night frequency:

	Rarely/never	1 to 3 times a month	1 to 3 times a week	Most nights
Child wakes, settles quickly (< 15 mins)				
Child wakes, takes 15 mins to hour to settle				
Child wakes, takes longer than hour to settle				
Child wakes more than once a night (specify how often)				

Additional details you may wish to give:

4.1.6 Communication - compared to a child of the same age

Can your child hear normally?	☐ Yes	☐ No
Are your child's speech, language and communication skills as you would expect for a child the same age?	☐ Yes	☐ No
Does your child understand what you say to them and the words/language used?	☐ Yes	☐ No
Does your child understand facial expressions, body language etc.?	☐ Yes	☐ No
Can your child tell you when they are not well?	☐ Yes	☐ No

If you answered No to any of the above please describe the issues your child has and any help you have to give them.

4.1.7 Social Skills - compared to a child of the same age

Does your child display appropriate problem solving skills for their age?	☐ Yes	☐ No
Does your child make decisions in an age-appropriate way?	☐ Yes	☐ No
Does your child cope well with any changes in their routine?	☐ Yes	☐ No
Can your child amuse themselves?	☐ Yes	☐ No

If you answered No to any of the above, please describe what happens and any effect this has on you and your family.

Do you need to spend more time preparing your child before they leave the house, compared to other children of the same age?	☐ Yes	☐ No
Does your child get fixated on certain things?	☐ Yes	☐ No

Does your child need assistance to look after personal belongings?	☐ Yes	☐ No
Does your child like to be on their own?	☐ Yes	☐ No
Does your child have difficulty playing or mixing with other children?	☐ Yes	☐ No
Does your child have difficulty participating in events?	☐ Yes	☐ No

If you answered Yes to any of the above, please describe what happens and any effect this has on you and your family.

4.1.8 Behaviour - compared to a child of the same age

Do they display any high risk behaviours that require intervention from others to protect them from injuring themselves or others?	☐ Yes	☐ No
Is your child regularly irritable/prone to outbursts and difficult to calm down?	☐ Yes	☐ No
Does your child appear to be significantly depressed or anxious or suffer panic attacks?	☐ Yes	☐ No
Does your child run away from home/school/social gatherings?	☐ Yes	☐ No
Is your child ever aggressive to others (e.g. shouting, biting or kicking etc.) to an unusual degree for their age?	☐ Yes	☐ No
Does your child show unusual/obsessive/repetitive or withdrawn behaviours?	☐ Yes	☐ No
Do you need to lock house hold items away (e.g. matches, cleaning fluids, knives etc.)?	☐ Yes	☐ No

If you answered Yes to any of the above, please describe what is involved, how often this happens and the level of help your child needs and how this affects family life.

4.1.9 Safety -

Does your child have any dangerous habits or obsessions (e.g. fire starting, fascination with water, not responding when in dangerous situations)?	☐ Yes	☐ No
Does your child put foreign objects such as stones, twigs etc. in his/her mouth, ears, nose regularly?	☐ Yes	☐ No
Does your child have poor comprehension or perception of road safety skills (for example would run across the road without looking)?	☐ Yes	☐ No
Does your child have any self-harming behaviours (for example hair pulling, head banging, hand biting etc.)?	☐ Yes	☐ No
Have you made any changes to your home or car to make it safe for your child?	☐ Yes	☐ No
Is your child a flight risk?	☐ Yes	☐ No

If you answered Yes for any of the above or if there are any other safety issues, please describe what is involved, how often it happens and the level of extra help or supervision your child needs as a result.

4.1.10 Sensory issues -

Does your child get distressed by sights/noises/smells etc. that do not bother other people and which can limit places that they can go?	☐ Yes	☐ No
Does your child find it difficult to function or communicate when they are experiencing sensory overload?	☐ Yes	☐ No
Is your child's clothing restricted because they cannot tolerate certain fabrics on their skin?	☐ Yes	☐ No

If you answered Yes for any of the above or if your child has any other sensory issues, please describe what is involved, how often it happens and the level of extra help or supervision your child needs as a result.

4.1.11 Additional Needs -

Please detail any additional care needs that your child has and which you provide, including how often and for how long.

Examples might include:

— Use of specialist equipment.

— Techniques to help breathing.

— Special feeding arrangements.

— Dialysis.

— Dressing wounds.

— Stoma care requirements.

— Preparation of and/or administration of medication.

— Special transport arrangements.

4.1.12 Other issues -

Does your child's disability mean that it is difficult to arrange child care? ☐ Yes ☐ No

Does it prevent your family from going out together? ☐ Yes ☐ No

Please describe how your child's disability affects family life or other family members.

Is there any other additional information you wish to provide:

Part 4.2 Therapies

Is your child attending or waiting for an appointment for any of the following. Please print the word 'Yes' in the "waiting on appointment" or "attending therapy" columns.

Service	Waiting on appointment	Attending therapy	Date Referred	Reports available
Speech and Language			2 0	☐ Yes ☐ No
Occupational Therapy			2 0	☐ Yes ☐ No
Psychology			2 0	☐ Yes ☐ No
Psychiatry			2 0	☐ Yes ☐ No
Physiotherapy			2 0	☐ Yes ☐ No
Paediatrician			2 0	☐ Yes ☐ No
Hospital Consultant			2 0	☐ Yes ☐ No
Dietician			2 0	☐ Yes ☐ No
Optician			2 0	☐ Yes ☐ No
Audiologist			2 0	☐ Yes ☐ No
Behavioural Support			2 0	☐ Yes ☐ No
Social Worker			2 0	☐ Yes ☐ No
Public Health Physician			2 0	☐ Yes ☐ No
Other			2 0	☐ Yes ☐ No

IF THE CHILD IS ATTENDING ANY OF THE ABOVE SERVICES, PLEASE ENCLOSE THE RELEVANT REPORTS IF AVAILABLE. IF AN "ASSESSMENT OF NEED" HAS BEEN CARRIED UNDER THE DISABILITY ACT 2005, PLEASE ATTACH A COPY.

Send this completed application form and all relevant reports to:

Domiciliary Care Allowance Section
Social Welfare Services
Department of Social Protection
College Road
Sligo

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.

Part 5 Permission to release medical information

Please sign the authorisation below, which will allow your doctor to give this Department the necessary medical information for your application for Domiciliary Care Allowance.

Your doctor should then complete Part 6 and 7 of this form.

The medical information provided will be reviewed by one of our medical assessors and will be treated in strictest confidence. Although a confidential document, medical and non-medical people will need to deal with this report.

Authorisation

I permit my doctor to provide you, the Department of Social Protection, with medical information that you may need for this application for Domiciliary Care Allowance.

If you cannot sign your name, make a mark, such as an X, and have a witness sign their name beside it.

Date: D D M M 2 0 Y Y Y Y

Signature (**not** block letters)

Part 6 To be completed by the child's G.P./Specialist

Dear Doctor,
To enable us, on behalf of your patient, to accurately assess their eligibility for Domiciliary Care Allowance, please complete the medical report below. The medical information provided will be reviewed by our medical assessors and will be treated in strictest confidence.

The Freedom of Information Act provides for the disclosure of medical or psychiatric information directly to your patient. Where the disclosure of the information to the patient might have a negative effect on their physical or mental health or well-being, this information may instead be given to a medical practitioner, nominated by the claimant.

1. **Patient's details**
   Surname:
   First name:
   Address:
   Date of birth: D D M M Y Y Y Y
2. **Your patient since:** D D M M Y Y Y Y
3. **Diagnosis (use BLOCK LETTERS):**
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 12 months ☐ 12-24 months
   ☐ 24-48 months ☐ indefinitely

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

7. Please give:

Medical History

Surgical History

Clinical Findings

Hospital admissions

Date of most recent admission: D D M M Y Y Y Y

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

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

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 their ability in each of the following areas.

Should ability in any area be inappropriate to the age of the child, please tick N/A.

Area **Ability level**

	Normal	Mild	Moderate	Severe	Profound	N/A
Mental health						
Behaviour						
Intelligence						
Learning						
Consciousness/Seizures						
Speech						
Communication						
Social Skills						
Vision						
Hearing						
Sensory issues						
Feeding/Diet						
Sleeping						
Washing						
Dressing						
Continence						
Mobility						
Balance/Co-Ordination						
Manual Dexterity						
Reaching/Lifting/Carrying						
Sitting/Standing						
Climbing Stairs						
Bend/Kneel/Squatting						
Fine Motor Skills (age appropriate)						
Gross Motor Skills (age appropriate)						

Medical Report

G.P./Specialist name:

DSP panel number:

Address:

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

Doctor's official stamp

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

All information given in this section is covered by the Data Protection Act and the Official Secrets Act.

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