Social Welfare Services
**HM 1**

**Data Classification R**

# 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**.

## 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 date of birth:** 28 02 1970

D D M M Y Y Y Y

**8. Your mother's birth surname:** KELLY

## 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

Social Welfare Services
**HM 1**

**Data Classification R**

# Application form for Homemaker's Scheme

## 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 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 may be prosecuted. I undertake to immediately advise the Department of any change in my circumstances which may affect my continued entitlement under the Homemaker's Scheme.

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

**Signature** (**not** block letters)

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

D D M M 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

**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

**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

## Your work and claim details

**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:

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?**

D D M M Y Y Y Y

**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?**

D D M M Y Y Y Y

**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?**

☐☐ a week

Type of course:

☐ Vocational Training Opportunities Scheme (VTOS)

☐ FÁS Training

Other:

Please specify

## Part 3 — Your spouse's, civil partner's or cohabitant's details

**24. Their PPS No.:**

**25. Title:** (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

**26. Their surname:**

**27. Their first name(s):**

**28. Their birth surname:**

**29. Their date of birth:**

D D M M Y Y Y Y

**30. Their mother's birth surname:**

**31. Their address:**

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

## Part 4 Details of your qualified child(ren)

**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: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

Are/were 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 2

Surname:

First name(s):

PPS No.:

Date of birth: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

Are/were 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:

## Part 4 continued — Details of your qualified child(ren)

### Child 3

Surname:

First name(s):

PPS No.:

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

Are/were 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/were 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:

## Part 5 Details of person who needs or needed care

**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.:**

**34. Title:** (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

**35. Their surname:**

**36. Their first name(s):**

**37. Their birth surname:**

**38. Their date of birth:**

D D M M Y Y Y Y

**39. Their mother's birth surname:**

**40. Their address:**

During caring period.

**41. What is your relationship to this person?**

**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:

## Part 5 Details of person who needs or needed care

**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:

## Details of person who needs or needed care

**46. Have you or anyone else applied for Domiciliary Care Allowance for this person?**

☐ Yes ☐ No

**If 'Yes', please attach confirmation of Domiciliary Care Allowance.**

**47. What other type of payment are/were they getting, if any?**

**48. Name of country that pays/paid them:**

**49. Is/was anyone else getting Carer's Allowance, Carer's Benefit or Carer's Support Grant (formerly known as Respite Care Grant) for this person?**

☐ Yes ☐ No

**50. Is/was the person cared for working outside the home?**

☐ Yes ☐ No

If 'Yes', please state:

Employer's name:

Employer's address:

Type of work:

Number of hours: ☐☐ a week

**51. Is/was the person cared for attending a training or educational training course outside the home?**

☐ Yes ☐ No

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

☐☐ a week

Type of course:

☐ Vocational Training Opportunities Scheme (VTOS)

☐ FÁS Training

Other:

Please specify

**52. Is/was the person named above attending a day care or rehabilitative centre?**

☐ Yes ☐ No

A doctor must supply Medical Certificate details in **Part 8** for period(s) of care.

**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.**

## Part 5 continued — Details of person who needs or needed care

**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: 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.

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

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

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

**Signature** (**not** block letters)

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

## Part 7 Checklist

**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 Employment Affairs and Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments/benefits. Personal data may be exchanged with other Government Departments/Agencies where provided for by law. Our data protection policy is available at www.welfare.ie/dataprotection or in hard copy.**

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

## Part 8 Medical Report

**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:**

**is/was suffering from:**

**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 M M Y Y Y Y

To: D D M M Y Y Y Y

**Additional Information:**

**Doctor's name:**

**DSP panel number:**

**IMC number:**

**Address:**

**Doctor's official stamp**

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

D D M M 2 0 Y Y

**Data Protection Statement**

**The Department of Employment Affairs and Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments/benefits. Personal data may be exchanged with other Government Departments/Agencies where provided for by law. Our data protection policy is available at www.welfare.ie/dataprotection or in hard copy.**

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