Social Welfare Services Office
CARB1

Application form for Carer's Benefit

- Please read Information booklet - **SW 49** before completing this claim form.
- Please use BLOCK LETTERS and place a tick (✓) in the appropriate boxes.
- Please answer all questions fully as incomplete information may delay processing your claim.
- Please ensure that the person(s) receiving care from you sign(s) Part 9 of this form, and that the person(s) doctor completes the Medical Report.
- Don't forget YOU the Carer must sign Part 8.

If you need any help completing this form, please contact your local Social Welfare Office or Carer's Benefit Section.

Telephone: Longford (043) 40086 or 40087 or Dublin (01) 704 3000 Ext. 8786 or 8787

Part 1 Your own details

Please state: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____ Please specify

1. What is your full name?
Last name
First name(s)

2. What is your birth surname (your surname before you were married), if different?

3. Where do you live?
Address

4. What is your telephone number, if any?
Code | Local Number

5. What is your e-mail address, If any?

6. What is your date of birth?
☐☐ Day ☐☐ Month ☐☐☐☐ Year

7. What is your PPS No.? (Personal Public Service Number)

FIGURES	LETTER(S)

8. Are you?
'Cohabiting' means you live with a man or woman as husband or wife and you are not married to him or her.
☐ Married ☐ Single ☐ Separated
☐ Widowed ☐ Divorced ☐ Cohabiting

9. Have you ever claimed Carer's Benefit or Allowance before? ☐ Yes ☐ No

10. Are you getting any payment from this Department? ☐ Yes ☐ No

If yes, state type of payment.

Part 2 Your employment details

11. Please give details of your most recent or current employer:

Employer's name		
Address		
Telephone number	Code	Local Number

12. When did you start working with your current employer? (if applicable) Day Month Year

Please complete EITHER question 13 or 14

13. When did you commence caring? Day Month Year

If you have resigned from employment please enclose your P45

14. If you are currently employed, when do you intend to take leave for caring purposes? Day Month Year

Part 3 To be completed by your most recent or current employer

Important Note: All sections on part 3 must be completed even if you have left work. A P60 or P45 will not suffice.

15. Please state your employee's name

Employee's full name

16. What is your Employee's PPS No.?

Figures	Letter(s)

17. Please state number of hours worked by employee i.e. paid employment Weekly Fortnightly

18. Is this employment part-time or full-time? Part-time Full-time

19. If the employee is still working for you please give dates he or she intends to leave work for caring purposes.

From			To		
Day	Month	Year	Day	Month	Year

Please state type of leave Carer's Leave Other _____

Please specify

To be completed by your most recent or current employer

20. Please give details of employee's PRSI record for the 12 month period immediately before their carer's leave commences.

or

give details of employee's PRSI record immediately before they left your employment.

Period of Employment						Number of weeks	PRSI Class
From			To				
Day	Month	Year	Day	Month	Year		

21. If less than 52 weeks applies, state the number of weeks worked at 16 hours or more in the previous 26 week period. Please note the relevant 26 week period will be the last 26 weeks actually worked by the employee.

Signed by or on behalf of employer

Signature
(NOT block letters)

Position in Company or Organisation

Employer's Registered Number

E-mail address

Telephone number

Code Local number

Employer's Official Stamp

Date

Part 4 Your spouse's or partner's details

Please state: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____
Please specify

22. What is your spouse's or partner's full name?

Last name

First name(s)

23. What is their birth surname (their surname before they were married), if different?

24. Where do they live?

Address

25. What is their date of birth? ☐☐ Day ☐☐ Month ☐☐☐☐ Year

26. What is their PPS No.?

Figures							Letter(s)	

27. Is your spouse or partner getting any payment from this Department or the Health Service Executive*? ☐ Yes ☐ No

* From January 2005 the Health Boards were replaced by the Health Service Executive (HSE)

If 'Yes', please state:

Type of payment

Claim or Reference No.

28. Are they in employment? ☐ Yes ☐ No

29. Are they self-employed? ☐ Yes ☐ No

30. Are they getting an occupational pension? ☐ Yes ☐ No

If 'Yes', please state:
Who pays them this pension?

Name of person or Company

Address

Part 5 Qualified child details

31. Do you have a child or children under age 18, or aged between 18 and 22 in full-time education by day at a recognised school or college? ☐ Yes ☐ No

Part 5 continued — Qualified child details

If Yes, please give details here:

For children aged between 18 and 22 in full-time education please get a letter from the school or college to confirm that they are at college on a full-time basis.

List children here, showing eldest child first:						
Child's full name	Date of birth Day	Month	Year	PPS No.	Relationship to you	Is this child living with you?

Part 6 — Details of person(s) you are caring for

Please state:

	Person 1	Person 2
	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other (Please specify)	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other (Please specify)
32. What is their full name?	Last name First name(s)	Last name First name(s)
33. What is their birth surname (their surname before they married), if different?	Maiden name (if any)	Maiden name (if any)
34. What is their address?		
35. What is their date of birth?	Day Month Year	Day Month Year
36. What is their PPS No.?	Figures / Letter(s)	Figures / Letter(s)
37. What type of pension, benefit or allowance are they getting (if any) from this Department?		
Claim or reference number		

Details of person(s) you are caring for

	Person 1		Person 2	
38. Is a Domiciliary Care Allowance being paid by the Health Service Executive for this person?	☐ Yes	☐ No	☐ Yes	☐ No
	If 'Yes', please enclose documentary evidence.			
39. Does each person for whom you are providing care live with you?	☐ Yes	☐ No	☐ Yes	☐ No
If 'No', Please give the following details:				
Distance between households				
Is there a direct phone link?	☐ Yes	☐ No	☐ Yes	☐ No
If there is no phone link, is there any other type of direct link?	☐ Yes	☐ No	☐ Yes	☐ No
Give details				
40. Is the person named above attending a day care or rehabilitative centre?	☐ Yes	☐ No	☐ Yes	☐ No
If 'Yes', please state	Name of centre		Name of centre	
Note: You cannot be regarded as providing full-time care and attention where the person(s) being cared for stays overnight at the centre.	Address		Address	
41. What is the telephone number of the Rehabilitative Centre?	Code Local number		Code Local number	
Number of days they attend per week	Days	Per week	Days	Per week
Number of hours per day	Hours	Per day	Hours	Per day

Part 7 Your payment method details

Carer's Benefit is paid direct to your Bank or Building Society Account.
The advantages of getting your payment this way are:

- **it is lodged direct to your account on the day of payment**
- **it is available at a time and place that suits you**
- **there may be less delays and queuing.**

Dealings between you and your financial institution remain confidential. The Department does not have access to your Bank or Building Society Account.

Where do you want your payment? ☐ into a bank account ☐ into a building society

A Current or Deposit Account can be used to lodge the payment but a Mortgage Account cannot.

Bank or Building Society name

Bank or Building Society address

The account must be in your name or jointly held by you.

Name on the account

Please state which type of account you have ☐ Current account ☐ Deposit account

Account number

Sort code **available from branch**

If you do not have a bank or building society Account, please contact us to discuss alternative arrangements.

PART 8 Declaration by you – the carer

I apply for Carer's Benefit. All the information I have given is true.

I understand that a Social Welfare Inspector can investigate and review my entitlement to Carer's Benefit at any time. I have given full details of my means and I will tell the Department of Social and Family Affairs within 7 days of any change in my means.

To the best of my belief, the person(s) named in Part 8 requires full-time care and attention. I am the person providing full-time care and attention and I will tell the Department immediately if there is any change in circumstances affecting my entitlement.

Signed	Date

(**not** block letters)

If you (person providing care) cannot sign, make your mark and have it witnessed. The witness cannot be the person being cared for or a member of the carer's household.

Signed	Date

(**not** block letters)

Address of witness

Warning:
Penalty for false statements or withholding information: Fine or Imprisonment or both.

Send the completed application form to:

Carer's Benefit Section
Social Welfare Services Office
Government Buildings
Ballinalee Road
Longford

Telephone: Longford (043) 45211 ext. 8786 or 8787
Dublin (01) 704 3000 ext. 8786 or 8787

If you have any difficulty filling in this form, please phone us in Carer's Benefit Section at the telephone numbers listed above or call to your local Social Welfare Office.

DATA PROTECTION AND FREEDOM OF INFORMATION

We the Department of Social and Family Affairs, will treat all information and personal data which you give as confidential. We will only disclose it to other bodies in accordance with law. We are responsible for it under the Data Protection Act and Freedom of Information Act.

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

Note to carer

Important

You do not need to send a medical report at this stage for a person for whom a Domiciliary Care Allowance is being paid by the Health Service Executive.

The following medical forms are in two parts. **Have Part A completed by the person(s) being cared for**. If the person being cared for cannot complete this form, you should fill it in for them and have it signed by a witness.

You must then pass the entire medical form to the doctor of the person being cared for. **The doctor must complete Part B, questions 1 -7 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.

Medical report (person 1)

Part A (to be completed by the person being cared for)

Authorisation

I permit my doctor to provide you, the Department of Social and Family Affairs, with medical information that you may need for this application for Carer's Benefit.

I understand that I may need to attend a medical exam from time to time and that my entitlement to care under the Carer's Benefit scheme may be reviewed at any time.

Part A - Person 1

Your signature or mark	Date

(**not** block letters)

If you cannot sign, have somebody witness your authorisation and sign below on your behalf. A witness cannot be the carer or a member of the carer's household.

Signature of witness	Date

(**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.

Medical report (person 1)

Part 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 overleaf. 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 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.

The format of this medical report has been agreed between the IMO and this Department. It is standard for all sickness schemes. However, Carer's Benefit differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with a disability.

If you feel that a bare outline of the disability does not adequately address the need for care, please feel free to add any additional observations on the caring situation at Question 6. You may also attach copies of any reports or other documents that you feel demonstrate the need for full-time care.

If you have any queries, please contact the **Carer's Benefit Section** directly at **(043) 45211, ext. 8786 or 8787**

Note:

The carer should already have filled Part 1 Question 1 and Parts 6 and 8 of the application form. The person(s) being cared for must have completed Part A of this medical report section.

Part B - Person 1

1. Patient's full name and address:

Name

Address

Date of birth: Day Month Year

Your patient since: Day Month Year

2. Diagnosis (use BLOCK LETTERS)

3. Date incapacity started: Day Month Year

4. How long do you expect this incapacity to continue?

☐ 0-3 months ☐ 3-6 months ☐ 6-9 months

☐ 9-12 months ☐ 12-15 months ☐ indefinitely

5. If the answer to any of the questions listed below is Yes (Y), please give details in boxes provided

- Date of most recent hospital admission — Date of Discharge
- Attending a specialist ☐ Y/N
- On medication ☐ Y/N
- Other treatment ☐ Y/N
- Pregnant ☐ Y/N
- If 'Y', give EDD: Day Month Year

6. If you have any additional information in this case, give details here:

Part 2 - Person 1

7. Indicate the degree to which your patient's condition has affected their ability in each of the following areas

	Normal	Mild	Moderate	Severe	Profound
Mental health →	☐	☐	☐	☐	☐
Learning →	☐	☐	☐	☐	☐
Consciousness →	☐	☐	☐	☐	☐
Balance →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Lifting or carrying →	☐	☐	☐	☐	☐
Manual dexterity →	☐	☐	☐	☐	☐
Bending, kneeling or squatting →	☐	☐	☐	☐	☐
Sitting →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing stairs →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

A medical exam by one of our medical assessors may be required to determine eligibility under the Carer's Benefit scheme.

Is your patient fit to attend a medical exam? ☐ Yes ☐ No

If 'No', give details here:

Your signature

(**not** block letters)

Date

DSFA Panel Number

Address

Doctor's Official Stamp

Medical report (person 2)

Part A (to be completed by the person being cared for)

Authorisation

I permit my doctor to provide you, the Department of Social and Family Affairs, with medical information that you may need for this application for Carer's Benefit.

I understand that I may need to attend a medical exam from time to time and that my entitlement to care under the Carer's Benefit scheme may be reviewed at any time.

Part A - Person 2

Your signature or mark	Date

(**not** block letters)

If you cannot sign, have somebody witness your authorisation and sign below on your behalf. A witness cannot be the carer or a member of the carer's household.

Signature of witness	Date

(**not** block letters)

Note

In signing the authorisation above, you allow your doctor to issue to us the medical information that 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.

Medical report (person 2)

Part 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 overleaf. 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 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.

The format of this medical report has been agreed between the IMO and this Department. It is standard for all sickness schemes. However, Carer's Benefit differs from other schemes in that it is paid to the carer for providing full-time care and attention to the person with a disability.

If you feel that a bare outline of the disability does not adequately address the need for care, please feel free to add any additional observations on the caring situation at Question 6. You may also attach copies of any reports or other documents that you feel demonstrate the need for full-time care.

If you have any queries, please contact the **Carer's Benefit Section** directly at **(043) 45211, ext. 8786 or 8787**

Note:

The carer should already have filled Part 1 Question 1 and Parts 6 and 8 of the application form. The person(s) being cared for must have completed Part A of this medical report section.

Part B - Person 2

1. Patient's full name and address

Name

Address

Date of birth: Day Month Year

Your patient since: Day Month Year

2. Diagnosis (use BLOCK LETTERS)

3. Date incapacity started Day Month Year

4. How long do you expect this incapacity to continue?

☐ 0-3 months ☐ 3-6 months ☐ 6-9 months

☐ 9-12 months ☐ 12-15 months ☐ indefinitely

5. If the answer to any of the questions listed below is Yes (Y), please give details in boxes provided

- Date of most recent hospital admission Date of Discharge
- Attending a specialist ☐ Y/N
- On medication ☐ Y/N
- Other treatment ☐ Y/N
- Pregnant ☐ Y/N
- If 'Y', give EDD: Day Month Year

6. If you have any additional information in this case, give details here:

Part 2 - Person 2

7. Indicate the degree to which your patient's condition has affected their ability in each of the following areas.

	Normal	Mild	Moderate	Severe	Profound
Mental health →	☐	☐	☐	☐	☐
Learning →	☐	☐	☐	☐	☐
Consciousness →	☐	☐	☐	☐	☐
Balance →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Lifting or carrying →	☐	☐	☐	☐	☐
Manual dexterity →	☐	☐	☐	☐	☐
Bending, kneeling or squatting →	☐	☐	☐	☐	☐
Sitting →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing stairs →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

A medical exam by one of our medical assessors may be required to determine eligibility under the Carer's Benefit scheme.

Is the care recipient fit to attend a medical exam? ☐ Yes ☐ No

If 'No', give details here:

Your signature

(**not** block letters)

Date

DSFA Panel Number

Address

Doctor's Official Stamp

For Official use Only (Person 1)

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.

Suitable for CARB 1 ☐

Review

Examination Required ☐

Further Medical Evidence required ☐

Signed Medical Assessor

Date

For Official use Only (Person 2)

Suitable for CARB 1 ☐

Review

Examination Required ☐

Further Medical Evidence required ☐

Signed Medical Assessor

Date

Data Protection and Freedom of Information

We the Department of Social and Family Affairs, will treat all information and personal data which you give as confidential. We will only disclose it to other bodies in accordance with law. We are responsible for it under the Data Protection Act and Freedom of Information Act.

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