Application form for

Carer's Support Grant

Social Welfare Services
CSG 1

Data Classification R

What is the Carer's Support Grant?

The Carer's Support Grant is an annual payment made to carers who get Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance. It can also be paid to certain other carers providing full time care. Carers can use the grant in whatever way they wish. Often carers use the grant to pay for respite care.

Who can get the Carer's Support Grant?

You automatically qualify for the Carer's Support Grant if you get Carer's Allowance, Carer's Benefit, or Domiciliary Care Allowance. If you are not getting any of these payments, you may still qualify if you meet the conditions below.

To qualify you must:

- Be 16 years of age or over;
- Ordinarily reside in the State; **and**
- Care for the person full time for a continuous period of at least six months and this must include the first Thursday in June of the year you are claiming for.

During the 6 month caring period you cannot:

- Get Jobseeker's Benefit or Allowance;
- Sign on for credited contributions; **and**
- Work or attend an education or training course for more than 18.5 hours a week.

How do I apply?

If you are getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance, you do not need to apply for the Carer's Support Grant. We will automatically pay you every June. If you are not getting of any of these payments fill in the Carer's Support Grant (CSG1) form for each person you are caring for. You need a Personal Public Service (PPS) Number before you apply.

How to complete this application form

- Please tear off this page and use as a guide to filling in this form.
- Use BLACK ballpoint pen, BLOCK LETTERS and place an **X** in relevant boxes.
- Please answer all questions that apply to you, this is Part 1 to Part 3.
- Sign the Declaration in Part 1.
- The person you are caring for should sign the Authorisation in Part 5.
- You should then get the doctor to complete the medical report.
- The doctor of the person receiving care from you must also sign Part 5.

If you need any help to complete this form, please contact Carer's Support Grant Section on (043) 334 0000 or 0818 927 770, your local Intreo Centre, Social Welfare Office or any Citizen Information Centre.

For more information, visit **www.gov.ie/csg**

How to fill this form

To help us in processing your application:

- Print letters and numbers clearly.
- Use one box for each letter or number.

Please see example below.

1. Your PPS Number: 1 2 3 4 5 6 7 T

2. Title, insert an **X** or specify: Mr ☐ Mrs ☒ Ms ☐ Other ☐

3. Surname: M U R P H Y

4. First names: M A U R E E N

5. Your first name as it appears on your birth certificate: M A R Y

6. Your date of birth: 2 8 (D D) 0 2 (M M) 1 9 7 0 (Y Y Y Y)

Contact Details

7. Your address: 1 NEW STREET
OLD TOWN
DONEGAL TOWN
County DONEGAL Eircode A65F4E2

8. Your telephone number: 0 8 8 1 2 3 4 5 6 7

9. Your email address: MMURPHY@WELFARE.IE

SAMPLE

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Part 1 — Your own details (Carer's Details)

1. Your PPS Number:

2. Title, insert an **X** or specify: Mr ☐ Mrs ☐ Ms ☐ Other

3. Surname:

4. First names:

5. Your first name as it appears on your birth certificate:

6. Your date of birth: D D M M Y Y Y Y

Contact Details

7. Your address:

County Eircode

8. Your telephone number:

9. 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.

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

Signature **not** block letters.

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

Signature of witness **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.

Your own details

10. What country were you born in?

11. 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)

12. Are you getting any of the following:

Carer's Allowance?	☐ Yes	☐ No
Carer's Benefit?	☐ Yes	☐ No
Domiciliary Care Allowance?	☐ Yes	☐ No

If you were getting one of these payments on the first Thursday in June of the year in question, you do not have to complete this form and you will get the grant automatically for that year. If you are caring for more than one person, you will get a grant for each of them.

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? Y Y Y Y

13. Are you, or have you been, employed or self-employed, including farming, in the last two years?

☐ Yes ☐ No

If **yes**, please state:

Your occupation:

Periods of employment and how many hours worked each week, please insert dates below:

Period of employment 1

From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Hours: ☐☐ a week

Period of employment 2

From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

Hours: ☐☐ a week

Your own details

14. Are you attending or have you attended an educational or training course in the last two years?

☐ Yes ☐ No

If **yes**, please state:

Course attended: ☐ Vocational Training Opportunities Scheme (VTOS) ☐ SOLAS Training

If other, please specify:

Hours: a week

15. If you worked or attended an educational or training course in the last two years please have the following completed by your employer or training authority.

To be completed by Employer or Training Authority

I certify that is or 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 Eircode

Telephone Number: Mobile

Landline

I declare that the information given here is true and complete.
Signed by or on behalf of the Employer or Training Authority:

Official stamp

Signature **not** block letters.

Date: 2 0

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.

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Names of account holders:

Name 1:

Name 2, if any:

Post Office

Post Office address:

Part 3 Details of person you are caring for

16. Their PPS Number:

17. Their surname:

18. Their first names:

19. Their date of birth:

D D M M Y Y Y Y

20. What is your connection to the person being cared for?

21. When did you start providing full time care for them?

D D M M Y Y Y Y

22. Have you provided, or likely to provide, full time care and attention for a continuous period of at least six months?

☐ Yes ☐ No

Important: Carer's Support Grant is paid only when the six month period of care includes the first Thursday in June. For more information,visit **www.gov.ie/csg**

23. 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.

Details of person you are caring for

24. Has anyone else applied for the the Carer's Support Grant for the person named in Q17 and Q18?

☐ Yes ☐ No

If **yes**, please state:

What year did they last apply? ☐☐☐☐
Y Y Y Y

25. How many hours care do you provide each day?

Monday:	☐☐	Friday:	☐☐
Tuesday:	☐☐	Saturday:	☐☐
Wednesday:	☐☐	Sunday:	☐☐
Thursday:	☐☐		

26. Please specify the daily duties, including personal care and supervision, you perform in looking after this person.

27. Has the person being cared for worked in the last two years?

☐ Yes ☐ No

If **yes**, please state:

Employer's name:

Address:

County Eircode

Type of work:

Hours: ☐☐ a day

Days: ☐ a week

Details of person you are caring for

28. In the past two years had this person any overnight stays in a hospital, convalescent home or similar type of institution?

☐ Yes ☐ No

If **yes**, please state:

Hospital or home name:

Address:

County Eircode

Date spent there: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

29. If they don't live with you please state their address:

County Eircode

The distance between the households: kilometres

Is the above address a full time residential care facility, for example a nursing home?

☐ Yes ☐ No

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

☐ Yes ☐ No

Mobile

Landline

If **no**, please give details of other direct link:

Part 3 continued Details of person you are caring for

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

☐ Yes ☐ No

If **yes**, please state:

Surname of person:

First names:

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 Checklist

Have you

- Provided your PPS Number?
- Answered all the question that apply to you?
- Provided the PPS Number of the person you are caring for?
- Signed the declaration in Part 1?
- 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
Social Welfare Services
Government Buildings
Ballinalee Road
Longford
N39 E4E0

Telephone: (043) 334 0000 or 0818 927 770
If you are calling from outside of Ireland please call + 353 43 334 0000

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments or benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at **www.gov.ie/dsp/privacystatement** or as a 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 you are getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance and are caring full time for the person for a continuous period of at least six months which includes the first Thursday in June of the year you are claiming for. The Carer's Support Grant is paid automatically to anyone in these circumstances.

The following medical report is in two parts. **Section A is to be 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 give 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.

Medical Report for
Carer's Support Grant

Part 5 Medical Report

Section A

Applicant details (details of person providing full time care)

Surname:

First name:

PPS Number:

Declaration by person receiving full time care and attention

Authorisation

I need **full time care** and **attention** and the person named in **Part 1** of this form 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.

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

Signature **not** block letters of the person receiving care.

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.

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

Signature **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 Support Grant scheme.

One of our Medical Assessors will review the medical information and will treat it in the 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 on the following pages. The medical information provided will be reviewed by one of our Medical Assessors, who will treat it in the 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** on (043) 334 0000 or 0818 927 770

If you are calling from outside of Ireland please call + 353 43 334 0000

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 the application form, to the:

Carer's Support Grant Section
Government Buildings
Ballinalee Road
Longford
N39 E4EO

Section B continued

1. Patient details

Please use Block capitals

Surname:

First name:

Address:

Date of birth:

D D M M Y Y Y Y

PPS Number:

Mobile telephone Number:

The patient may be contacted by text message in relation to a medical assessment.

Occupation:

2(a). Your patient since:

D D M M Y Y Y Y

2(b). How often does the patient visit your surgery? ☐ Weekly ☐ Monthly ☐ Less often

3. Diagnosis, use BLOCK CAPITALS:

4. ICD10 Codes:

5. Date condition started:

D D M M Y Y Y Y

6. How long do you expect this condition to continue? ☐ less than 3 months ☐ 3-6 months ☐ 6-12 months ☐ 12-24 months ☐ indefinitely

7. Please give:

Medical history

Surgical/Obstetrical history

Attach relevant reports, test results and referrals

Hospital admissions

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

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: D D M M Y Y Y Y

Please attach any relevant reports and results of investigations.

Additional Information:

Medical Report

Ability/Disability Profile:

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

	Normal	Mild	Moderate	Severe	Profound
Mental Health/Behaviour →	☐	☐	☐	☐	☐
Learning/Intelligence →	☐	☐	☐	☐	☐
Consciousness/Seizures →	☐	☐	☐	☐	☐
Balance/Co-ordination →	☐	☐	☐	☐	☐
Vision →	☐	☐	☐	☐	☐
Hearing →	☐	☐	☐	☐	☐
Speech →	☐	☐	☐	☐	☐
Continence →	☐	☐	☐	☐	☐
Reaching →	☐	☐	☐	☐	☐
Manual Dexterity →	☐	☐	☐	☐	☐
Lifting/Carrying →	☐	☐	☐	☐	☐
Bending/Kneeling/Squatting →	☐	☐	☐	☐	☐
Sitting/Rising →	☐	☐	☐	☐	☐
Standing →	☐	☐	☐	☐	☐
Climbing Stairs/Ladders →	☐	☐	☐	☐	☐
Walking →	☐	☐	☐	☐	☐

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:

Doctor's name:

DSP panel number:

IMC number:

Address:

Doctor's Signature **not** block letters.

Doctor's official stamp

Date: D D M M Y Y Y Y

For Official use Only

(i) Eligible for Carer's Support Grant: ☐

(ii) Review:

(iii) DNRA: ☐

(iv) Not eligible for Carer's Support Grant: ☐

Give reasons:

Signed _____ **Department Medical Assessor**

Date: ☐☐ ☐☐ 2 0 ☐☐

D D M M Y Y Y Y

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