

# Application form for Carer's Benefit for additional person(s)

Social Welfare Services

**CARB 2**

Data Classification  
Confidential



## How to complete this application form.

You should only complete this form if you have completed a Carer's Benefit application form (CARB 1) and are claiming Carer's Benefit for additional person(s).

- 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.
- You need a Personal Public Service Number (PPS No.) before you apply

### Carer:

Please complete this form for each additional person(s) you are caring for and attach it to the application form **CARB 1**. Please fill in all details in **Parts 1** and **2**. The person you are caring for should sign **Section A** in **Part 3** confirming that they require care.

### Doctor:

Please fill in **Section B** in **Part 3** of the medical report. 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 Social Welfare Office or Citizens Information Centre.

For more information, log on to **[www.welfare.ie](http://www.welfare.ie)**.

You should apply for Carer's Benefit as soon as you start caring for someone. You could lose payment if you don't.

## 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.	<input type="checkbox"/>	Mrs.	<input checked="" type="checkbox"/>	Ms.	<input type="checkbox"/>	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 mother's birth surname:	K	E	L	L	Y														
8. Your date of birth:	2	8		0	2		1	9	7	0									
	D	D		M	M		Y	Y	Y	Y									

## Contact Details

9. Your address:	1		N	E	W		S	T	R	E	E	T								
	O	L	D		T	O	W	N												
	C	O		D	O	N	E	G	A	L										
10. Your telephone number:	0	8	6	1	2	3	4	5	6	7										
	MOBILE																			
	0	1	7	0	4	3	0	0	0											
	LANDLINE																			
11. Your email address:	M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E		

# SAMPLE



**Part 2**

**Details of person you are caring for**

**12. Their PPS No.:**

--	--	--	--	--	--	--	--	--	--

**13. Title:** (insert an 'X' or specify)

Mr.  Mrs.  Ms.  Other 

--	--	--	--	--	--	--	--

**14. Their surname:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**16. Their birth surname:**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**17. Their date of birth:**

D	D	M	M	Y	Y	Y	Y		

**18. Their address:**


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

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**20. What is your relationship to the person you are caring for?**

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**21(a). Date you started caring for this person:**

D	D	M	M	Y	Y	Y	Y		

**(b). Has anyone paid you to look after this person since this date?**

Yes  No

**22. Are they getting Domiciliary Care Allowance?**

Yes  No

**23. If 'No', have you or anyone applied for Domiciliary Care Allowance for them?**

Yes  No

**24. What other type of payment are they getting, if any?**


Please name only the social welfare payment(s) from Ireland or another country.

**25. Is the person named above attending a day care or rehabilitative centre?**

Yes  No

**26. Do they stay overnight in any of these centres?**

Yes  No

**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.



27. If the person stays overnight at a care facility or centre, please state:

Name of centre:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Address of centre:


Telephone number of centre:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

LANDLINE

Number of hours they attend:

--	--	--

 a day

Number of days they attend:

--	--

 a week

Please attach letter of confirmation from day care centre.

28. Does the person you are caring for live with you?

Yes       No

If 'No', please state:

Number of hours you will be providing care while on Carer's Leave:

--	--	--

 a day

Number of days you will be providing care while on Carer's Leave:

--	--

 a week

Does 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 phonenumber between the households?

Yes       No

If 'No', please give details of other direct link in the space provided.

--

Details of daily duties you perform looking after this person:

--

Note

Please answer the above question fully if the person you are caring for does not live with you.



## Note to carer

### Important

**You do not need to send a medical report at this stage for a child for whom Domiciliary Care Allowance is being paid by this Department.**

The following medical forms are in two parts. **Have Section A completed and signed by the person being cared for.**

You must then pass the entire medical form to the doctor of the person being cared for. The doctor may return the form to you in a sealed envelope to keep their patient's medical details confidential.

Please make sure you return the medical form along with your application.

### 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](http://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.



# Medical Report for Carer's Benefit for additional person(s)



## Part 3

## Medical Report

### 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 Benefit.

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 Benefit scheme may be reviewed at any time.

Date:        
D D M M Y Y Y Y

Signature (not block letters)

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:        
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 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.



## Section B

**Section 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 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 Benefit Section** at LoCall: 1890 92 77 70.

**Note:**

The carer should already have filled Parts 1 and 2 of the application form. The person(s) 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 BENEFIT SECTION.**





Section B

1. Patient details

Surname: [Grid of 20 boxes]

First name: [Grid of 20 boxes]

Address: [Grid of 20 boxes, 4 rows]

Date of birth: [DD] [MM] [YYYY]
D D M M Y Y Y Y

PPS No.: [Grid of 8 boxes]

Mobile telephone No.: [Grid of 12 boxes]

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

2. Your patient since:

[DD] [MM] [YYYY]
D D M M Y Y Y Y

3. Diagnosis(es) (use BLOCK CAPITALS):

[Grid of 20 boxes, 2 rows]

4. ICD10 Code(s):

[Grid of 8 boxes] [Grid of 8 boxes]

5. Date condition started:

[DD] [MM] [YYYY]
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

Hospital admissions

Date of discharge:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

Result of relevant investigations

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

Attending a specialist

On medication

Other treatment

9. Pregnant:

Yes       No

If 'Yes', give EDD:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y

Please attach any relevant reports/results of investigations.

**Additional Information:**





For official use only

(i) Eligible for Carer's Benefit:

(ii) Review:

(iii) DNRA:

(iv) Not eligible for Carer's Benefit:

Give reasons:

Signed \_\_\_\_\_ Medical Assessor

Date:

D D

M M

2 0

Y Y Y Y

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](http://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.

