# Application form for Disability Allowance

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

### If you do not have a spouse, civil partner or cohabitant:

If you do not have a spouse, civil partner or cohabitant, fill in **Parts 1, 2, 3, 4, 5**, and **6**. You should sign **Part 10** confirming that you allow your doctor to give us the medical information needed to decide if you qualify for Disability Allowance. When form is completed, read **Part 9** and sign declaration in **Part 1**.

## If you have a spouse, civil partner or cohabitant:

If you have a spouse, civil partner or cohabitant, fill in **Part 1**, **2**, **3**, **4**, **5**, **6**, **7** and **8**. You should sign **Part 10** confirming that you allow your doctor to give us the medical information needed to decide if you qualify for Disability Allowance. When form is completed, read **Part 9** and sign declaration in **Part 1**.

#### **Doctor:**

Please fill in the medical report at **Part 10**. 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.

## 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	Т									
2. Title: (insert an 'X' or specify)	Mr.			Mrs	s. [X	(	Ms	i. [			(	Oth	er				
3. Surname:	M	U	R	Р	Н	Y											
4. First name(s):	M	Α	U	R	Е	E	N										
5. Your first name as it appears on your birth certificate:	M	A	R	Y													
6. Birth surname:	M	С	D	Ε	R	M	0	Т	Т								
7. Your mother's birth surname:	K	Ε	L	L	Y												
8. Your date of birth:	2	8		0	2		1	9	7	0							

## **Contact Details**

9. Your address:	1		N	Ε	W		S	T	R	Ε	Ε	Т						
	0	L	D		Т	0	W	N										
	С	0		D	0	N	E	G	Α	L								
10.Your telephone number:	0	8	6	1	2	3	4	5	6	7								
number.	M	) B	ΙL	E											•			
	0	1	7	0	4	3	0	0	0									
	LA	NI	D L	ΙN	Е													
11.Your email address:	M	M	U	R	Р	Н	Υ	<u>@</u>	W	Ε	L	F	Α	R	Ε	I	Ε	



# Application form for

# Disability Allowance





Part 1	You	r ow	n (	det	tail	s (	pe	ers	on	W	ho	15	d	ısa	bl	ed	or	1l.
1. Your PPS No.:				1							Г			İ		İ		
<b>2. Title:</b> (insert an 'X' or specify)	Mr.	Mrs	S		Ms.				O.	the	r [							
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	М	M	L	Υ	Y	Υ	Υ										
		Cor	ntac	ct I	Deta	ail	S											
9. Your address:																		
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					+	$\frac{1}{1}$					$\frac{1}{1}$							=
											_							=
10.Your telephone number:													M	0 1	3	. Е		
													L	A N	D	LII	1 E	
11.Your email address:																		
											T							一
		Б	1		. •													
		D	ecla	ara	at10	n												
I declare that all the information I will tell the Department when If you cannot sign your name, n	my mea	ns or o	circu	mst	ance	es c	han	ge.		ness	s sig	(n th	neir	nar	ne l	oesi	de it	t.
											Г				_	_		
						υa	ite:	L	D [	)		ΛΙ	M	_ ,	2   Y	0   Y '	ΥY	/
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	You	r ow	'n	det	ails	(p	ers	on	W	ho	is	d	isa	bl	ed	or	ill
12.Are you?	Divo	ried rated						-	A so A fo u w	Civurvi orm ere	vil P ving er C in a	artı g Ci Civil ı Ci	vil F Par vil P	rtne Parti	ner	•	
13.If you are married, in a ci	vil partr	nershi <sub>l</sub>		r coh	abiti Y Y		ron	n wh	nat	dat	e?						
14.Do you live on an island off the coast of Ireland? If 'Yes', please state name of this island:	Yes			N	0												
Part 2	You	r wo	rk	an	d cl	air	n c	let	ail	S							
Disability Allowance is a means which includes say Please include written ex If you are married, in a cit the means of your spouse increase for a qualified at Please complete fully the If no income, please enter 15. Are you currently in empty of the means of your spouse increase for a qualified at the lease complete fully the lease complete fully the lease enter the means of your please enter the means of your please enter the lease of the lea	vings, providence sivil partre, civil partre, civil public.  e remainer 0 in each	ropert such a nershi artnei ader o ach bo	y (constant) y (co	other tater r coh coh	thar nents abiti abita	n yo s and ng v nt e	ur o d pa vith ven	own aysli sor if y	hor ps v neo ou a	ne) with ne are	, fo yo , yo not	reig ur a u n cla	gn p app nust nimi	ens lica t als	sions tion so de an	et	C.
	Yes			_ N	0												
If 'Yes', please state: Employer's name:																	
Employer's address:																	
																$\perp$	
If your work is confidence of Gross weekly earnings: €  16(a). Are you self-	Please a			r mos	a st rec	wee	ek		, pie	ease	atta	ach	me	dica	I evi	der	ice
employed?	Yes			_ N	U												



# Your work and claim details

16(b).lf you are or ha	ve been	self-	emp	loye	d, p	leas	se s	tate	:											
Type of work you do	0:																			
Dates of self- employment:	From:																			
	То:	D I	)	M	М		Υ	Y	Y	<b>Y</b>										
Net yearly earnings	: €			],			].[			a ye	ar									
This is the money	you hav	e ma	de fr	om s	self-	em	plo	yme	nt a	fte	r <b>de</b>	du	cti	ng	оре	erat	ing	ex	per	ises
17(a). Do you own or	work a	farm	of la	and?																
If 'Yes', please state: Size of farm or land		Y	es	acı	res	N	lo													
Net yearly income:	€		],[																	
'Net yearly income'	is mone	y you	have	e ma	de fr	rom	the	farn	n <b>af</b>	ter	dec	luc	ting	<b>5</b> O	pera	ating	g ex	креі	nses	5.
17(b). If your farm or	land is	let, p	leas	e sta	te n	et y	/ea	rly in	ıcoı	ne	froi	n l	etti	ing	•					
Net yearly income:	€					٦.														
18(a). Are you taking as it applies to										u in	ser	t a	n X	in		e Ye				
Community employme	ent:	Y	⁄es			N	lo			D	D			M 1	M		Y	Y	Υ	Υ
Rural Social Scheme:		Y	⁄es			N	lo			D	D			<i>A I</i>	M		Y	Y	Y	Y
Area-Based Initiative:		Y	⁄es			N	lo			D	D		_	M 1	M		Y	Y	Υ	Y
Back to Work Scheme:		Y	⁄es			N	lo			D	D			И	M		Y	Y	Υ	Y
Vocational Training Opportunities Scheme	:	Y	⁄es			N	lo			D	D			M I	M		Y	Y	Y	Υ
Back to Education Allowance:		Y	⁄es			N	lo			D	D			M I	M		Y	Y	Υ	Y
Community Services Programme:		Y	⁄es			N	lo			D	D			<b>M</b>	M		Y	Y	Y	Y
FÁS course or schemes	5:	Y	⁄es			N	lo			D	D			<b>1</b>	M		Y	Y	Y	Y
Other course (such as rehabilitative course):	a	Y	⁄es			N	lo				D				M		Y	Y	Y	Y
School or college:		Y	⁄es			N	lo							<u> </u>	M		Y	Y	Y	Y

# Your work and claim details

•	ou ge	et paid	lor	aoir	ng thi	S SCI	iem	e or	CO	urs	e.							
1	€	<b>],</b>				a	wee	k										
19.If you are receiving ma	inten	ance,	plea	se s	tate:													
Amount:	€	],				a	wee	k										
20.If you are receiving ma paying:	inten	ance,	plea	se s	tate t	he a	ımoı	ınt	of n	nor	tga	ge (	or re	ent	you	ı are	9	
Amount:	€					a	wee	k										
Please attach a statem	ent fr	om le	ndin	g ag	ency	or a	ren	t re	ceip	ot f	rom	yo	ur l	and	llor	d.		
21. Are you getting a socia	al seci	urity p	oaym	ent	from	ano	ther	COL	untı	ry?								
		Yes				lo												
If 'Yes', please state: Name of country:																		
Your claim or reference number:																		
Amount:	€					a	wee	k										
	Se	ease a	Age	псу	confi	rmir			-					m t	he S	Soci	al	
22. Are you getting any ot	her p	ensio	n or a	allov	vance	?												
If 'Yes', please state:		Yes			No	)												
Who pays this pension:																		
						_												
Your claim or reference number:																		
number:	€					a	wee	k k										
number:	Ple	ease a		the	mos	t re	cent	pay					fro	m t	he į	peo	ple	
number:	Ple wh	o pay	you	the	mos firmi	t re	cent ne al	pay bov	e ar	noı	ınt.							ny
number: Amount:	Ple wh	o pay	you	the	mos firmi	t reeng to	cent ne al	pay bov	e ar	noı	ınt.							ny
number: Amount:  23.Do you have savings or other financial institution.  If 'Yes', please state:	Ple wh r acco ion?	o pay ounts	you in a b	the con	e mos firmi a, pos	t reeng to	cent ne al	pay bov	e ar	noı	ınt.							ny
number: Amount:  23.Do you have savings or other financial institut:  If 'Yes', please state:  Name of financial institution:	Ple wh r acco ion?	o pay ounts	you in a b	the con	e mos firmi a, pos	t reeng to	cent ne al	pay bov	e ar	noı	ınt.							ny
number: Amount:  23.Do you have savings or other financial institut  If 'Yes', please state:  Name of financial	Ple wh r acco ion?	o pay ounts	you in a b	the con	e mos firmi a, pos	t reeng to	cent ne al	pay bov	e ar	noı	ınt.							ny
number: Amount:  23.Do you have savings or other financial institut:  If 'Yes', please state:  Name of financial institution:	Ple wh r acco ion?	o pay ounts	you in a b	the con	e mos firmi a, pos	t reeng the	cent ne al	pay bov	e ar	noı	ınt.							ny
number: Amount:  23.Do you have savings or other financial institut:  If 'Yes', please state:  Name of financial institution: Sort code: Account number:	Ple wh r acco ion?	o pay ounts	you in a b	the con	e mos firmi a, pos	t reeng the	cent ne al	pay bov	e ar	noı	ınt.							ny



Part 2 continued	Your work and claim details
	Financial Institution 2
Name of financial institution: Sort code:	
Account number:	
Current balance: €	
Name of account holder:	
	Financial Institution 3
Name of financial institution:	
Sort code:	
Account number:	
Current balance: €	
Name of account holder:	
	Financial Institution 4
Name of financial institution:	
Sort code:	
Account number:	
Current balance: €	
Name of account holder:	
Please attach a statement fo	or <b>each</b> account, showing balance for the last <b>six</b> months.
24.Have you made or do you	intend to make a claim for compensation?
	Yes No
If 'Yes', please give details	in the space provided:

Your work and claim details Part 2 continued 25. Do you own stocks, shares or investments? Yes No If 'Yes', please state: Name of company: Number of shares held: Their value: Please attach a statement to show details. 26. Do you have property apart from your home? Yes No If 'Yes', please state: Type of property: Address of property: 'Property' would be an apartment, business property, another house or land other than that mentioned at question 17. Current market value: € Please attach a statement from Auctioneer/Valuer confirming current market value. **Outstanding** € mortgage on property: If mortgaged please attach a recent statement from lending institution.

Note: A separate sheet of paper can be used for details of any additional properties that you have.



# Your work and claim details Part 2 continued 27. Do you have any other income? No If 'Yes', please give details in the space provided: 28. Did you sell or transfer property or business in the last three years? Yes No If 'Yes', please give details in the space provided and attach a copy of the deed of transfer: 29. If you have moved from your home, please give details in the space provided if your home is rented, occupied by other people or otherwise being used:

30.If you have recently sold your home to buy another, please outline the circumstances in the space provided and attach a copy of the deed of transfer:



Part 3	Habitual Residence Condition
31.What country were you born in?	
32. What is your nationality?	
33. When did you come to live in the Republic of Ireland?	D D M M Y Y Y Y
34. Have you lived outside th within the last five years?	e Republic of Ireland for any period longer than three months
	Yes No
If 'Yes', please give details	of where you lived in the space provided.
	Country 1
Country:	
From:	
To:	
Why you lived there:	D D M M Y Y Y Y
	Country 2
Country:	
From:	
To:	
Why you lived there:	D D M M Y Y Y Y
Tring you lived there.	
	For official use only
HRC satisfied HRC	not satisfied HRC1 issued

## Your payment details

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

				P	ost	: O	ffic	ce												
Post Office address:																				
If you are unable to collect ( (known as an agent) to do s		_			_								nd y	ou/	waı	nt s	om	eor	ie e	lse
Your agent's name:																				
Your agent's address:																				
								Da	ate:		D	D		M	M		2   Y	0 Y	Y	Y
I agree to act as agent for the										. u		·	. 0.	,						
For more information, log of								Da	ate:		D	D		M	M		2 Y	<b>0</b>	Y	Y
For more information, log of Signature of agent (not block letters)											D	D		M	M		2 Y	<b>0</b> Y	Y	Y
Signature of agent (not block lette	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	Y
Signature of agent (not block letter)  You will find	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	Y ion.
Signature of agent (not block letters)  You will find the same of financial institution:	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	Y ion.
Signature of agent (not block letter)  You will find	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	Y ion.
Signature of agent (not block letter)  You will find the Name of financial institution:  Address of financial	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.
Signature of agent (not block letter)  You will find the Name of financial institution:  Address of financial	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.
Signature of agent (not block letter)  You will find the Name of financial institution:  Address of financial	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.
Signature of agent (not block letter)  You will find the Name of financial institution:  Address of financial	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.
Signature of agent (not block letter)  You will find the Name of financial institution: Address of financial institution:	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.
Signature of agent (not block letter)  You will find the state of financial institution:  Address of financial institution:  Sort code:	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.
Signature of agent (not block letters)  You will find the state of financial institution:  Address of financial institution:  Sort code:  Account number:	ers)	F	ina	an	cia	l Ir	nsti	itu	tio	n									Y	ion.

Please attach a recent bank statement.

Part 5	L	Jei	aı.	IS (	OI	yo	ur	qı	ıaı	111	ea	CI	111	<b>a</b> (1	ren	L)			
35. How many children do you wish to claim for?			ag	e 18	8 - 2	e 18 22 ir cati	ı ful	l-		fro	m t	he :	sch	ach ool d d 18	or c	olle		mati the	ion
Please state child's:	Chi	ld 1																	
Surname:																			
First name(s):																			
PPS No.:																			
Date of birth:	D	D		М	M		Υ	Υ	Υ	Υ									
	Chi	ld 2	:								1	1							
Surname:																			
First name(s):																			
PPS No.:																			
Date of birth:	D	D		A.A.	M		Y	Y	Y	V									
	Chi			IVI	IVI		I	ı	ı	1									
Surname:																			
First name(s):																			
PPS No.:																			
Date of birth:				D 4				2/											
	D Chi			M	M		Y	Y	Y	Y									
Surname:		14 4																	
First name(s):																			
PPS No.:																			
Date of birth:	D	D		M	M		Y	Y	Υ	Y									
	Chi	ld 5																	
Surname:																			
First name(s):																			
PPS No.:																			
Date of birth:	D	D		M	M		Y	Y	Y	Y									

Note: A separate sheet of paper can be used for details of other children you have.

## Other payments

### Living Alone Increase

You may get a Living Alone Increase if you are getting a **Disability Allowance** and live alone or mainly alone. For more information, log on to **www.welfare.ie**.

36.	Dο	VOII	wish	to	claim	a I	iving	Alone	Increase?
50.	$\mathbf{D}$	you	441311	LU	Ciaiiii	u		AIUIIC	mici casc.

Yes No

If 'Yes', please state date you started living alone or mainly alone:

D D M M Y Y Y Y

### Household Benefits Package

You may qualify for the Household Benefits Package. Which is made up of 3 allowances:

- Electricity or Gas Allowance
- Telephone Allowance and
- Free Television Licence

For more information, log on to www.welfare.ie.

#### Fuel Allowance

This allowance is subject to your household composition. Only one person in a household can get this allowance.

37. Do you wish to apply for a Fuel Allowance?

Yes No

If 'No', please go to Part 7.

If 'Yes', please complete fully the remainder of this section. Do not leave any question blank. If no income, please enter 0 in each box.

38. The following people live with me:

	Person 1
Surname:	
First name(s):	
PPS No.:	
Are they:	Employed Self-employed
If so, state weekly amount:	€
Are they:	☐ In receipt of a social welfare payment ☐ Other
If in receipt of a social w	relfare payment or other, please give details in the space provided:

Weekly amount:

€ , . . .

Part 6 continued	Other payments
	Person 2
Surname:	
First name(s):	
PPS No.:	
Are they:	Employed Self-employed
If so, state weekly amount:	
Are they:	In receipt of a social welfare payment Other
If in receipt of a social w	elfare payment or other, please give details in the space provided:
Weekly amount:	
	Person 3
Surname:	
First name(s):	
PPS No.:	
Are they:	Employed Self-employed
If so, state weekly amount:	
Are they:	In receipt of a social welfare payment Other
If in receipt of a social w	elfare payment or other, please give details in the space provided:
Weekly amount:	



Part 6 continued	Other payments
	Person 4
Surname:	
First name(s):	
PPS No.:	
Are they:	Employed Self-employed
If so, state weekly amount: €	
Are they:	In receipt of a social welfare payment Other
If in receipt of a social well	fare payment or other, please give details in the space provided:
Weekly amount: <b>€</b>	

### **Extra benefits**

For more information on extra benefits available to pensioners, log on to www.welfare.ie.



Part 7	)	oui	spo	us	e's,	ci	vil	pa	ırtı	<b>1er</b>	's (	or (	coh	ab	ita	nť	s d	leta	ils
39.Their PPS No.:																			
<b>40.Title:</b> (insert an 'X' or specify)	Mr.		Mrs	S. [		Ms				C	)the	er							
41. Their surname:																			
42.Their first name(s):																			
43. Their birth surname:																			
44.Their mother's birth surname:										1									
45. Their date of birth:	D	D	M	M		Υ	Υ	Y	Y										
46.Their address:																			
Only answer this question if you are married or in a civil partnership and do not live together.																			
Part 8			r spo k an			-			_		er	's	or	co	ha	bit	ar	ıt's	ı
<b>48.Are they employed at pro</b> If 'Yes', please state:	eser	nt? Yes			1	No													
48. Are they employed at pro	eser				¬ ,	.1.													
If 'Yes', please state:																			
Employer's name:																			
Employer's address:																			
Gross weekly earnings: €  Number of days worked:	Plea		ttach eek	<b>.</b> thei	r mo	ost r		wee nt p		lip									
49. Are they self-employed a	t pr	esen	t?																
If 'Yes', please state:		Yes			1	No													
Type of work they do:																			
Date they started self-employment:	D	D	M	M		Y	Y	Y	Y										
Net yearly earnings: €									a	yeaı									
This is the money they ha	ave	mad	e fron	n se	lf-e	mpl	loyr	ner	nt a	fter	de	duc	tin	g op	era	tin	g ex	креі	nses
																	EEE	EE	

# Your spouse's, civil partner's or cohabitant's work and claim details

50(a). Do they own or wo	rk a tarm ot iai	10:					
If 'Yes', please state:	Yes	☐ No					
Size of farm or land:		acres					
Net yearly income:	€						
'Net yearly income' is m	oney they have	made from the f	arm <b>after</b> deduc	cting opera	ting ex	pense	es.
50(b). If their farm or land	d is let, please s	state net yearly	/ income from l	etting:			
Net yearly income:	€						
51(a). Are they taking paras it applies to the			ted if they inse				
Community employment:	Yes	No					
			D D	MM	Y	/ Y	Y
Rural Social Scheme:	Yes	No					
			D D	MM	Y	/ Y	Y
Area-Based Initiative:	Yes	No				/ V	
Pack to Work Schomo	Voc	□ No	D D	MM		T	ľ
Back to Work Scheme:	Yes	∐ No	D D	MM	Y	/ Y	Y
Vocational Training	Yes	No				<u> </u>	
Opportunities Scheme:			D D	MM	Y	/ Y	Y
Back to Education Allowance:	Yes	☐ No	D D	M M	Y	/ Y	Y
Community Services	Yes	No					
Programme:			D D	MM	Y	/ Y	Υ
FÁS course or schemes:	Yes	No					
			D D	MM	Y	/ Y	Y
Other course (such as a rehabilitative course):	Yes	No					
•			D D	MM	Y	/ Y	Y
School or college:	Yes	∐ No	D D	M M		/ V	
				141 141			
51(b). Please state what t	they get paid fo	or doing this scl	neme or course	) <b>:</b>			
	€,	a	week				
52.If they are receiving m	aintenance, ple	ease state:					
Amount:	€	a	week				



# Your spouse's, civil partner's or cohabitant's work and claim details

53. Are they getting a social	secu	ırity p	ayn	nent	t fro	m a	ano	the	r co	ount	try?								
		Yes				V٥													
If 'Yes', please state:				1							1				1				
Name of country:																			
Their claim or reference number:																			
Amount: €		,					a	wee	k										
	Plea	se at	tach	the	e mo	ost	rec	ent	pa	ysliį	p or	let	ter	fro	m t	he S	Soci	al	
	Secu	urity /	<b>Age</b> ı	псу	con	firn	nin	g th	e a	bov	e a	mοι	ınt.						
54. Are they getting any other	er pe	ensior	ı or	allo	war	ice?	?												
		Yes			_ N	V٥													
If 'Yes', please state:					1 1											1			
Who pays this pension:																			
Their claim or reference number:																			
Amount: €		,					a	wee	k										
	Plea	ise at	tach	_ the	e mo	ost	rec	ent	pa	yslij	o or	· let	ter	fro	m t	he i	peo	ple	
		pay								-									
55. Have they savings or according other financial institution		s in a	bar	ık, p	ost	off	ice	, bu	ildi	ng s	soci	ety,	cre	edit	un	ion	or a	any	
		Yes			_ N	V٥													
If 'Yes', please state:	Fina	ncial	Inst	itut	ion	1													
Name of financial institution:						•													
Sort code:									•						•				
Account number:																			
Current balance: €			<b>.</b> .																
Name of account holder:																			
	Eina	ncial	Inct	i++	ion	2		'							•				
Name of financial institution:		IIICIAI	11150	litut		_													
Sort code:																			
Account number:																			
Current balance: €																			
Name of account holder:																			

# Your spouse's, civil partner's or cohabitant's work and claim details

	Fin	anc	ial	Inst	itut	ion	3											
Name of financial institution:																		
Sort code:																		
Account number:																		
Current balance: €				],[														
Name of account holder:																		
	Fin	anc	ial	Inst	itut	ion	4											
Name of financial institution:																		
Sort code:																		
Account number:																		
Current balance: €				],[														
Name of account holder:																		
Please attach a statement	for e	ach	acc	וווס	nt s	how	/ing	hala	anc	e fo	r the	ا د	t ci	v m	ont	hs.	 	
							0	Duit	a 110	0 10		, ia	JC 31	A 111		115.		
56.Do they own stocks, share	res (			tm	ents	_												
If 'Yes', please state:		Ye	S		L	<u> </u>	No											
Name of company:																		
Number of shares held:				],[														
Their value: €				],[														
	Ple	ease	atta	ach	a st	aten	nen	t to	sho	w d	etai	ls.						
57. Have they property apart	fror	n th	eir	ho	ne?	•												
If 'Yes', please state:	,	Yes				No	0											
Type of property:																		
Address of property:																		
'Property' would be an apartment, business					Ī		Ī		Ť	Ť				İ				
property, another house	T				T				Ť									
or land other than that mentioned at question 50.				$\frac{\perp}{\parallel}$	$\frac{\perp}{\parallel}$		<u> </u>		$\frac{\perp}{\perp}$							+		
	$\dashv$				<u>_</u> ] [								_					
Current market value: 🗲						- 1	- 1			'								
Current market value: €	<b>,</b>	, Δυσ	tion	eer eer	],	luer	COT	•  ofirm	ning	ر الماري الماري	ren	t m	arka	at vo	مبياد			
Please attach a statement fr	om ,	Auct	tion	eer,	/Va	luer	cor	•  nfirm	ning	cui	ren	t m	arke	et va	alue	•		
<b>-</b> L	om ,	Auct	tion	eer,	,	luer	cor	•   nfirm •	ning	CUI	ren	t m	arke	et va	alue	•		

Note: A separate sheet of paper can be used for details of any additional properties that they have.



# Your spouse's, civil partner's or cohabitant's work and claim details

58.Do they have any other income?
Yes No
If 'Yes', please give details in the space provided:
59. Did they sell or transfer property or business in the last three years?
Yes No
If 'Yes', please give details in the space provided and attach a copy of the deed of transfer:
60. If they have moved from their home, please give details in the space provided if their home is rented, occupied by other people or otherwise being used:
61. If they have recently sold their home to buy another, please outline the circumstances in the space provided and attach a copy of the deed of transfer.

#### Have you enclosed the following?

- Your and your spouse's, civil partner's or cohabitant's most recent payslips

  (if you or your spouse, civil partner or cohabitant were employed during the last 12 months)
- Statements from financial institutions for the last 6 months
   (if you or your spouse, civil partner or cohabitant have money, investments or shares in a financial institution)
- Statements from lending agency or rent receipt from landlord (if you are receiving maintenance)
- Letter from school or college
   (if you have child(ren) aged between 18 and 22 who are in full-time education)
- Letter from doctor stating your work is of a rehabilitative nature

If you were born, married or entered into a civil partnership or a civil union outside the Republic of Ireland:

- Your birth certificate
- Your marriage certificate or civil partnership or civil union registration certificate
- Your spouse's, civil partner's or cohabitant's birth certificate (if applying for an increase for them)
- Your child(ren)'s birth certificate(s) (if applying for an increase for them)
  Note: No birth certificate is needed if you are already getting Child Benefit.

Original certificates only.

Remember to send in all the certificates and documents with this application, or say that you will send them later.

Please remember your claim cannot be processed without the medical part being completed.

## Please remember to sign the Declaration in Part 1.

# Please also fill in Part 10 and then give this form to your doctor who will complete Part 11 (Medical Report).

The medical report is quite detailed, so your doctor may not be able to complete it immediately. They may ask you to return to collect the fully completed form. To keep your details confidential the doctor may tear away the medical report portion of the form and return it to you in a sealed envelope. When you are returning the application form to us, make sure that you include this sealed envelope containing the medical report with all other documents and certificates you must supply. (See checklist above.)



## Send this completed application form to:

**Disability Allowance Section** 

Social Welfare Services Government Buildings Ballinalee Road Longford

LoCall: 1890 92 77 70 (from the Republic of Ireland only)

If you are calling from outside the Republic of Ireland please call + 353 43 3340000

Important: If you do not claim within 7 days you could lose benefit.

#### Note

The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

#### **Data Protection and Freedom of Information**

We, the Department of Social Protection, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies according to the law.

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

Edition: March 2011



**KKKKK** 

## Medical Report for

# Disability Allowance



### Part 10

## 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 Disability Allowance. **Your doctor should then complete Part 11 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.

Permission								
permit my doctor to provide you, the Department information that may be required for my applicatio				-		dical		
	Date:					2	0	
Signature (not block letters)		D	D	M	M	Y	Y	Y
Signature (not block loctors)								
f you are unable to sign, have your mark witnessed an	d have the	e witr	iess s	ign b	elow 1	for yo	ou:	
	Date:					2	0	
	Date.	D	D	M	M	Y	Y	Y
Witness Signature (not block letters)	I							

### Part 11

## Medical report by your doctor

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess their eligibility/continued eligibility for Disability Allowance, please complete the medical report overleaf. The medical information provided will be reviewed by our medical assessors and will be handled 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.

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.



Part 11		M	edi	ica	l r	еp	or	t b	уу	701	ır	do	cto	r						
1. Patient details														1						
Surname:																				
First name:																				
Address:																				
Date of birth:																				
	D	D		M	M		Y	Y	Y	Y										
PPS No.:																				
Mobile telephone No.:																				
The patien	t ma	y be	со	nta	ctec	l by	tex	t m	essa	age	in r	elat	ion	to a	a me	edic	al a	sses	sm	ent
Occupation:																				
2. Your patient since:																				
	D	D		M	M		Y	Y	Y	Y										
3. Diagnosis(es) (use BLOCK CAPITALS):																				
1. ICD10 Code(s):																				
5. Date condition started:																				
	D	D	•	M	M		Y	Y	Y	Y	-									
6. How long do you expect this condition to		les	s th	an	3 m	ontl	hs			3-6	ó mo	onth	าร			6-	12 r	non	ths	
continue?		12	-24	mo	nths	5				inc	defii	nite	ly							
7. Please give:																				
Medical history																				
Surgical/Obstetrical history																				
ilistoi y																				



Part 11 continued	Medical report by your doctor
Hospital admissions	
Relevant investigations	
o Bloom of a late that a	
8. Please give details if any o	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
	eports/results of investigations.
Additional Information:	

# Medical report by your doctor

ABILITY/DISABILITY PROFILE:

	7 (DIEIT 17 <b>D</b> 157 (D	ALITT I KOT	166		
10.Indicate the degree to whic following areas.	h your patient's	condition	has affected t	heir ability	in ALL of the
ionoving areas.	Normal	Mild	Moderate	Severe	Profound
Mental Health/Behaviour —	<b></b>				
Learning/Intelligence ———	<b>→</b>				
Consciousness/Seizures —					
Balance/Co-ordination ——	<b>→</b>				
Vision —	<b>→</b>				
Hearing —	<b>→</b>				
Speech —					
Continence —					
Reaching —	<b>→</b>				
Manual Dexterity —					
Lifting/Carrying —	<b></b>				
Bending/Kneeling/Squatting					
Sitting/Rising —					
Standing —	<b></b>				
Climbing Stairs/Ladders —	<b></b>				
Walking —	<b></b>				
11.A Medical Assessment by o	ne of the Depar	tment's M	edical Assesso	rs may be r	equired to
determine eligibility.	modical accord	oont?	$\neg$		
Is your patient fit to attend a	medical assessin	nent:	Yes	No	
If 'No', give details here:					
This section is only relevant	to Companio	n Free Tra	vel Pass ann	lications	
12. Does the patient use a whe	•				
12. Boes the patient use a whe	Yes	No	cilianene sas	13.	
13.Is the patient registered wit		_	the Blind or I	National Le	ague of the
Blind of Ireland?	Yes	No			
		_			
This section is only relevant			-		
14(a). Is the customer suitable purposes?	for work/traini Yes	ng for reha	abilitative and	occupation	nal therapy
14(b). Are there any health and	d safety issues v	vith regard	to the employ	yment/trai	ning
described?	Yes	No			
If the answer to question (a)					
is No or to question (b) is Yes, please provide details:					
res, pieuse provide details.					

Part 11 continued	Medical report by your doctor
Doctor's name:  DSP panel number:  Address:	IMC number:
Doctor's Signature (not block letter  Date:  D  M  M	Doctor's official stamp  2 0



For Official use Only	
1. Customer PPSN No.:	
2. Diagnosis:	
3. ICD10 Code(s):	
Medical Assessor's Opinion	
(i) Eligible for Disability Allowance:	
(ii) Eligible for companion pass:	Yes No
(iii) Medical Review Date:	D D M M Y Y Y Y
(iv) DNRA:	
(v) Not eligible for Disability Allowance:	
Give reasons:	
Signed	Medical Assessor
Date:	20

#### **Data Protection and Freedom of Information**

We, the Department of Social Protection, will treat all information and personal data you give as confidential. We will only disclose it to other people or bodies according to the law.

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