



Application form for Disability Allowance

How to complete application form for Disability Allowance.

- Please tear off this page and use 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 or partner:

If you do not have a spouse or partner fill in **Parts 1, 2, 3, 4, 5, and 6** as they apply to you. 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 or partner:

If you have a spouse or partner please fill in **Part 1, 2, 3, 4, 5, 6, 7 and 8** as they apply to you. 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 in first page of 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 1 continued

Your own details (person who is disabled or ill)

12. Are you? Single Widowed Divorced
 Married Cohabiting Separated

13. If you are married or cohabiting, from what date?
D D M M Y Y Y Y

14. Do you live on an island off the coast of Ireland? Yes No

If 'Yes', please state name of this island:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Part 2

Your work and claim details

Disability Allowance is a means tested payment. You are legally obliged to declare all your means which includes savings, property (other than your own home), foreign pensions etc. Please include written evidence such as statements and payslips with your application.

If you are married or you are living with someone as husband and wife, you must also declare the means of your spouse or partner irrespective of whether you are claiming an increase for a qualified adult.

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

15. If you are employed, please state:

Employer's name:

Employer's address:

If your work is considered to be of a rehabilitative nature, please attach medical evidence

Gross weekly earnings: € , . a week

Please attach your most recent payslip

16. If you are or have been self-employed, please state:

Type of work you do:

Dates of self-employment:

From:

To:

D D M M Y Y Y Y

Net yearly earnings: € , . a year

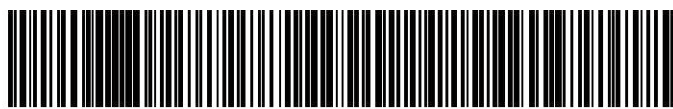
This is the money you have made from self-employment after deducting operating expenses.

17. If you own, work or rent a farm or land, please state:

Size of farm or land: acres

Net yearly income or rent from farm or land: € , .

'Net yearly income' is money you have made from the farm **after** deducting operating expenses.



18(a). If you are taking part in any of the following courses or schemes, insert an X in the box as it applies to you and give the date you started if you insert an X in the Yes box.

			Date you started:			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Yes	No	D	D	M	M
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Community employment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Area-Based Initiative:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back to Work Scheme:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vocational Training Opportunities Scheme:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back to Education Allowance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Community Services Programme:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FAS course or schemes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other course (such as a rehabilitative course):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School or college:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

18(b). Please state what you get paid for doing this scheme or course:

€ , . a week

19. If you are separated and receiving maintenance, please state:

Amount: € , . a week

20. If you are receiving maintenance from your ex-spouse or ex-partner, please state the amount of mortgage or rent you are paying:

Amount: € , . a week

Please attach a statement from lending agency or a rent receipt from your landlord.

21. If you are getting a social security payment from another country, please state:

Name of country:

Your claim or reference number:

Amount: € , . a week

Please attach the most recent payslip or letter from the Social Security Agency confirming the above amount.



22. If you are getting any other pension or allowance, please state:

Who pays this pension:

Your claim or reference number:

Amount: € , . a week

Please attach the most recent payslip or letter from the people who pay you confirming the above amount.

23. If you have savings or accounts in a bank, post office, building society, credit union or any other financial institution, please state:

Financial Institution 1

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 2

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 3

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 4

Name of financial institution:

Account number:

Current balance: € , .

Please attach a statement for **each** account, showing balance for the last **six** 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:

25. If you own stocks, shares or investments, please state:

Their value: € , .

Please attach a statement to show details.



26.If you have property apart from your home, please state:

Type of property:

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Address of property:

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'Property' would be an apartment, business property, another house or land other than that mentioned at question 17.

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Current market value: €

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Rent from this property: €

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 a week

27.If you have any other income please give details in the space provided:

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28.If you sold or transferred any property or business in the last three years please give details in the space provided and attach a copy of the deed of transfer.

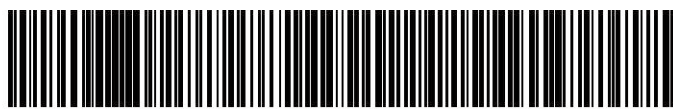
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29.If you have moved from your home, please give details in the space provided if your home is rented, occupied by other people or otherwise being used:

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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.

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31. What country were you born in?

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32. What is your nationality?

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33. When did you come to live in the Republic of Ireland?

D	D	M	M	Y	Y	Y	Y								

34. Have you lived in the *common travel area all of your life including the last 2 years?

Yes
 No

If 'No', please complete questions 35 to 38.

If 'Yes', please give details of where you lived in the space provided.

Country 1

Country:

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From:

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To:

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D D M M Y Y Y Y

Why you lived there:

Country 2

Country:

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From:

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To:

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D D M M Y Y Y Y

Why you lived there:



Country 3

Country:

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From:

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To:

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D D M M Y Y Y Y

Why you lived there:

Note

The *common travel area is Ireland, Great Britain, the Isle of man and the Channel Islands. You can spend brief periods on short holidays, studying or travelling outside the common travel area and still may be habitually resident here.

If you live in Northern Ireland, Great Britain, the Isle of Man or the Channel Islands, please provide proof of residence. Residency may be verified by production of a passport or identity card and one or more of the following: employment records such as P45, P60, bank statements, details of benefit payments, utility bills, rent or mortgage agreements or receipts for local authority charges.

35. Have you lived at the same address for the last 2 years?

Yes No

If 'No', please give details of where you lived in the space provided.

Last address:

From:

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To:

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D D M M Y Y Y Y

Previous address:

From:

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To:

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D D M M Y Y Y Y



36. Have you lived continuously in Ireland since the day you arrived?

Yes No

37. Does any of your close family, for example, parent, brother, sister or child, live in Ireland?

Yes No

If 'Yes', please give their details in the space provided.

Person 1

Their surname:

Grid for surname: 20 empty boxes

Their first name(s):

Grid for first name(s): 20 empty boxes

Their address:

Grid for address: 4 rows of 20 empty boxes each

Their date of birth:

Grid for date of birth: DD MM YYYY format

Their relationship to you:

Grid for relationship: 20 empty boxes

When they came to Ireland:

Grid for arrival date: DD MM YYYY format

Person 2

Their surname:

Grid for surname: 20 empty boxes

Their first name(s):

Grid for first name(s): 20 empty boxes

Their address:

Grid for address: 4 rows of 20 empty boxes each

Their date of birth:

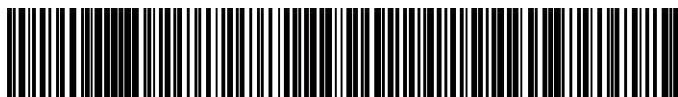
Grid for date of birth: DD MM YYYY format

Their relationship to you:

Grid for relationship: 20 empty boxes

When they came to Ireland:

Grid for arrival date: DD MM YYYY format



Person 3

Their surname: [grid]

Their first name(s): [grid]

Their address: [grid]

Their date of birth: [DD] [MM] [YYYY]
D D M M Y Y Y Y

Their relationship to you: [grid]

When they came to Ireland: [DD] [MM] [YYYY]
D D M M Y Y Y Y

Person 4

Their surname: [grid]

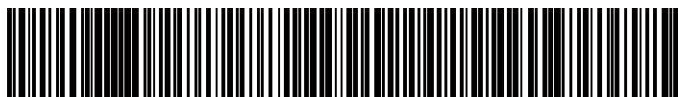
Their first name(s): [grid]

Their address: [grid]

Their date of birth: [DD] [MM] [YYYY]
D D M M Y Y Y Y

Their relationship to you: [grid]

When they came to Ireland: [DD] [MM] [YYYY]
D D M M Y Y Y Y



Financial Institution

You will get the following details printed on statements from your financial institution.

Name of financial institution:

[Grid for Name of financial institution]

Address of financial institution:

[Grid for Address of financial institution]

Sort code:

[Grid for Sort code]

Account number:

[Grid for Account number]

Name(s) of account holder(s):

Name 1:

[Grid for Name 1]

Name 2 (if any):

[Grid for Name 2]

Please attach a recent bank statement.

Part 5

Details of your qualified child(ren)

39. How many children do you wish to claim for?

[Grid for number of children] under age 18, age 18 - 22 in full-time education

You must attach written confirmation from the school or college for the children aged 18 - 22

Please state child's:

Child 1

Surname:

[Grid for Surname]

First name(s):

[Grid for First name(s)]

PPS No.:

[Grid for PPS No.]

Date of birth:

[Grid for Date of birth] DD MM YYYY

Child 2

Surname:

[Grid for Surname]

First name(s):

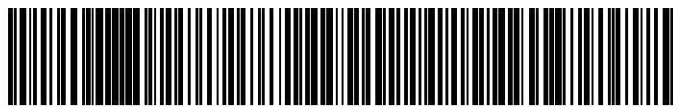
[Grid for First name(s)]

PPS No.:

[Grid for PPS No.]

Date of birth:

[Grid for Date of birth] DD MM YYYY



Child 3

Surname:

First name(s):

PPS No.:

Date of birth:

D D M M Y Y Y Y

Child 4

Surname:

First name(s):

PPS No.:

Date of birth:

D D M M Y Y Y Y

Child 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.

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.

40. If you wish to claim a Living Alone Increase, please state:

Date you started living alone or mainly alone:

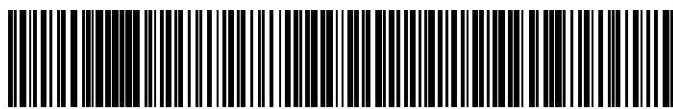
D D M M Y Y Y Y

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.

41. 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.

42. 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 welfare payment** or **other**, please give details in the space provided:

Weekly amount: € , .

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 welfare 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 welfare payment** or **other**, please give details in the space provided:

Weekly amount: € , .

Person 4

Surname:

First name(s):

PPS No.:

Are they: Employed Self-employed

If so, state weekly amount: € , .

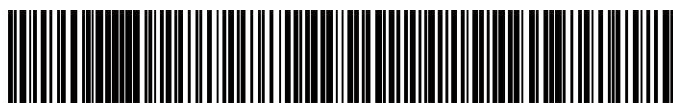
Are they: In receipt of a social welfare payment Other

If in receipt of a **social welfare payment** or **other**, please give details in the space provided:

Weekly amount: € , .

Extra benefits

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



Part 7

Your spouse's or partner's details

43. Their PPS No.:

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44. Title: (insert an 'X' or specify)

Mr.

Mrs.

Ms.

Other

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45. Their surname:

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46. Their first name(s):

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47. Their birth surname:

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48. Their mother's birth surname:

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49. Their date of birth:

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D D

M M

Y Y Y Y

50. Their address:

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Only answer this question if you are married and do not live together.

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Part 8

Your spouse's or partner's work and claim details

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

51. If they are employed at present, please state:

Employer's name:

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Employer's address:

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Gross weekly earnings: € , . a week

Please attach their most recent payslip

Number of days worked: a week

52. If they are self-employed at present, please state:

Type of work they do:

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Date they started self-employment:

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

D D

M M

Y Y Y Y

Net yearly earnings: € , . a year

This is the money they have made from self-employment after deducting operating expenses.

53. If they own, work or rent a farm or land, please state:

Size of farm or land:

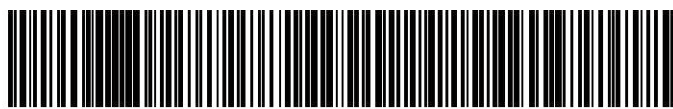
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 acres

Net yearly income or rent from farm or land:

€ , .

'Net yearly income' is money they have made from the farm **after** deducting operating expenses.



54(a). If they are taking part in any of the following courses or schemes, insert an X in the box as it applies to them and give the date they started if they insert an X in the Yes box.

			Date they started:		
	Yes	No	DD	MM	YYYY
Community employment:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Area-Based Initiative:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back to Work Scheme:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Vocational Training Opportunities Scheme:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back to Education Allowance:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Community Services Programme:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
FAS course or schemes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other course (such as a rehabilitative course):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
School or college:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

54(b). Please state what they get paid for doing this scheme or course:

€ , . a week

55. If they are separated and receiving maintenance, please state:

Amount: € , . a week

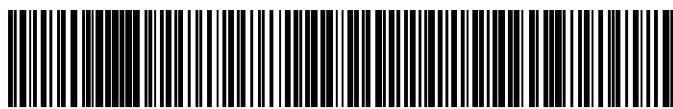
56. If they are getting a social security payment from another country, please state:

Name of country:

Their claim or reference number:

Amount: € , . a week

Please attach the most recent payslip or letter from the Social Security Agency confirming the above amount.



57. If they are getting any other pension or allowance, please state:

Who pays this pension:

Their claim or reference number:

Amount: € , . a week

Please attach the most recent payslip or letter from the people who pay them confirming the above amount.

58. If they have savings or accounts in a bank, post office, building society, credit union or any other financial institution, please state:

Financial Institution 1

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 2

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 3

Name of financial institution:

Account number:

Current balance: € , .

Financial Institution 4

Name of financial institution:

Account number:

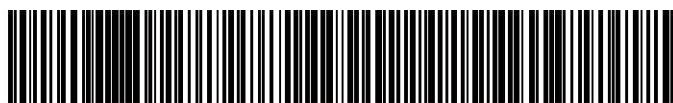
Current balance: € , .

Please attach a statement for each account, showing balance for the last six months.

59. If they own stocks, shares or investments, please state:

Their value: € , .

Please attach a statement to show details.



Have you enclosed the following?

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

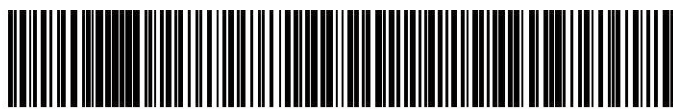
If born or married outside the Republic of Ireland:

- **Your birth certificate**
- **Your marriage certificate**
- **Your spouse's or partner'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.

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)

Telephone: Dublin (01) 704 3000

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

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

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

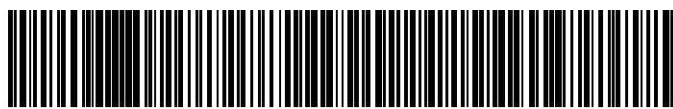
Note

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.





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

I permit my doctor to provide you, the Department of Social and Family Affairs, with medical information that may be required for my application for Disability Allowance.

Date:

D D
M M
Y Y Y Y

Signature (not block letters)

If you are unable to sign, have your mark witnessed and have the witness sign below for you:

Date:

D D
M M
Y Y Y Y

Witness Signature (not block letters)

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 DSFA 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.



Hospital admissions

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:

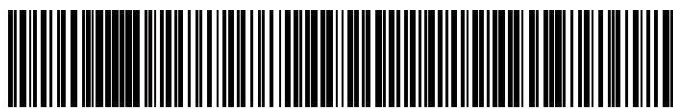
D D

M M

Y Y Y Y

Please attach any relevant reports/results of investigations.

Additional Information:



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 →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning/Intelligence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness/Seizures →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance/Co-ordination →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Dexterity →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting/Carrying →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Kneeling/Squatting →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting/Rising →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs/Ladders →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

This section is only relevant to Companion Free Travel Pass applications

12. Does the patient use a wheelchair for mobility, on a permanent basis?

Yes No

13. Is the patient registered with the National Council for the Blind or National League of the Blind of Ireland?

Yes No

This section is only relevant to Illness Benefit Exemptions

14(a). Is the customer suitable for work/training for rehabilitative and occupational therapy purposes?

Yes No

14(b). Are there any health and safety issues with regard to the employment/training described?

Yes No

If the answer to question (a) is No or to question (b) is Yes, please provide details:



Doctor's name:

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DSFA panel number:

--	--	--	--	--

IMC number:

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

Address:

--

Doctor's Signature (not block letters)

Doctor's official stamp

Date:

--	--

D D

--	--

M M

2	0		
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Y Y Y Y



For Official use Only

1. Customer PPSN No.:

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2. Diagnosis:

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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

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Y Y Y Y

(iv) DNRA:

(v) Not eligible for Disability Allowance:

Give reasons:

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Signed _____ Medical Assessor

Date:

--	--

D D

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M M

2	0		
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Y Y Y Y

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