



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. If a question does not apply to you, please leave the answer area blank.
- You need a Personal Public Service Number (PPS No.) before you apply.

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. You should have your doctor complete **Part 11**. When form is completed, read **Part 9** and sign declaration in **Part 1**.

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. You should have your doctor complete **Part 11**. When form is completed, read **Part 9** and sign declaration in **Part 1**.

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. Mrs. Ms. 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	1	7	0	4	3	0	0	0						
---	---	---	---	---	---	---	---	---	--	--	--	--	--	--

LANDLINE

0	8	6	1	2	3	4	5	6	7					
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--

MOBILE

11. Your email address:

M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E		

SAMPLE

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.If you have made or intend to make a claim for compensation, please state amount of compensation you have claimed or are about to claim:

€ , .

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

Their value: € , .

Please attach a statement to show details.



Part 3

Habitual Residence Condition

31. What country were you born in?

Grid for country name

32. What is your nationality?

Grid for nationality name

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

Grids for Day, Month, Year

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

Yes/No checkboxes

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

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

Country 1

Country:

Grid for Country 1 name

From:

Grids for Country 1 start date

To:

Grids for Country 1 end date

D D M M Y Y Y Y

Why you lived there:

Large text box for Country 1 explanation

Country 2

Country:

Grid for Country 2 name

From:

Grids for Country 2 start date

To:

Grids for Country 2 end date

D D M M Y Y Y Y

Why you lived there:

Large text box for Country 2 explanation



Financial Institution

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

Name of financial institution: [grid]

Sort code: [grid]

Account number: [grid]

Name(s) of account holder(s):

Name 1: [grid]

Name 2 (if any): [grid]

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] under age 18
[grid] 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:

Surname: [grid]

First name(s): [grid]

PPS No.: [grid]

Surname: [grid]

First name(s): [grid]

PPS No.: [grid]

Surname: [grid]

First name(s): [grid]

PPS No.: [grid]

Surname: [grid]

First name(s): [grid]

PPS No.: [grid]

Surname: [grid]

First name(s): [grid]

PPS No.: [grid]

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



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.



60. If they have property apart from their home, please state:

Type of property:	<input type="text"/>
Address of property:	<input type="text"/>
'Property' would be an apartment, business property, another house or land other than that mentioned at question 53.	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
	<input type="text"/>
Current market value: €	<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"/>
Rent from this property: €	<input type="text"/> , <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/> <input type="text"/> a week

61. If they have any other income please give details in this space provided:

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

63. 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:

64. 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?

- **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)
- **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 and Family Affairs, 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
2 0 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
2 0 Y Y Y Y

Witness Signature (not block letters)

Part 11

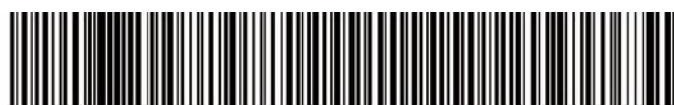
Medical report by your doctor

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.



1. Patient details

Surname:

[Grid for Surname]

First name:

[Grid for First name]

Address:

[Grid for Address]

Date of birth:

[Grid for Date of birth with labels D D M M Y Y Y Y]

PPS No.:

[Grid for PPS No.]

Mobile telephone No.:

[Grid for Mobile telephone No.]

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

Occupation:

[Grid for Occupation]

2. Your patient since:

[Grid for Date of patient since with labels D D M M Y Y Y Y]

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

[Grid for Diagnosis(es)]

4. ICD10 Code(s):

[Grid for ICD10 Code(s)]

5. Date condition started:

[Grid for Date condition started with labels D D M M Y Y Y Y]

6. How long do you expect this condition to continue?

[Radio buttons for duration: less than 3 months, 3-6 months, 6-12 months, 12-24 months, indefinitely]

7. Please give:

Medical history

[Text area for Medical history]

Surgical/Obstetrical history

[Text area for Surgical/Obstetrical history]



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:



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:

--	--

D D

--	--

M M

2	0		
---	---	--	--

Y Y Y Y

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