Application form for
Respite Care Grant

How to complete application form for Respite Care Grant.

- 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.

Applicant:

If fill in **Parts 1, 2 and 3** as they apply to you. When form is completed, sign declaration in **Part 1**.

The person being cared for:

Please complete and sign **Section A** in **Part 4** of the medical report.

Doctor:

Please fill in **Section B** in **Part 4** of the medical report. Please make sure you sign and stamp this part of the form.

Complete this form if you are caring for one care recipient. If you are caring for two or more please contact Respite Care Grant Section at (01) 704 3240 and they will forward the correct form RCG 1(a) for each additional person to you. Alternatively you can download this form from **www.welfare.ie**.

If you need any help to complete this form, please contact your local Social Welfare Office or Citizen Information Centre or the Respite Care Grant Section at (01) 704 3240.

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: MURPHY

4. First name(s): MAUREEN

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

6. Birth surname: MCDERMOTT

7. Your mother's birth surname: KELLY

8. Your date of birth: 28 02 1970
D D M M Y Y Y Y

Contact Details

9. Your address:
1 NEW STREET
OLD TOWN
CO DONEGAL

10. Your telephone number: 0861234567
MOBILE
01704300 00
LANDLINE

11. Your email address: MMURPHY@WELFARE.IE

Application form for
Respite Care Grant

For Official Use Only
Carer _____
Caree _____

Social Welfare Services
RCG 1

Part 1 — Your own details

1. **Your PPS No.:**
2. **Title:** (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other
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 M M Y Y Y Y

Contact Details

9. **Your address:**
10. **Your telephone number:**

MOBILE

LANDLINE

11. **Your email address:**

Declaration

I declare that all the information I have given on this form is accurate.
I will tell the Department when my circumstances change.

Signature (**not** block letters)

Date: D D M M 2 0 Y Y

Warning: If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

Your own details

12. What country were you born in?

13. Are you?

☐ Single ☐ Widowed ☐ Remarried ☐ Divorced

☐ Married ☐ Cohabiting ☐ Separated

14. Are you getting Carer's Allowance or Carer's Benefit?

☐ Yes ☐ No

If you were getting Carer's Allowance/Benefit on the first Thursday in June of the year in question, you do not have to complete this form, you will get the Grant automatically for that year. Only one grant is paid for each person receiving full time care and attention.

If 'No', have you ever applied for Carer's Allowance or Carer's Benefit?

☐ Yes ☐ No

If 'Yes', what year did you apply? ☐☐☐☐ (Y Y Y Y)

15. Have you ever applied for Respite Care Grant?

☐ Yes ☐ No

If 'Yes', what year did you apply? ☐☐☐☐ (Y Y Y Y)

16. Are you, or have you been getting Jobseeker's Allowance or Jobseeker's Benefit or are you or have you been signing for credited contributions in the last 18 months?

☐ Yes ☐ No

If you are working or attending an educational or training course outside the home for more than 15 hours a week you do not qualify for the Respite Care Grant.

17. Are you, or have you been, employed outside the home in the last 18 months?

☐ Yes ☐ No

If 'Yes' please indicate periods of employment and how many hours worked each week:

From: ☐☐ ☐☐ ☐☐☐☐

To: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

Hours: ☐☐ a week

From: ☐☐ ☐☐ ☐☐☐☐

To: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

Hours: ☐☐ a week

From: ☐☐ ☐☐ ☐☐☐☐

To: ☐☐ ☐☐ ☐☐☐☐ (D D M M Y Y Y Y)

Hours: ☐☐ a week

18. If you are, or have you been, self-employed outside the home in the last 18 months in any capacity, including farming, Back to Work Enterprise Allowance Scheme, please have the following completed by your accountant.

To be completed by Accountant

I certify that [ ] is/was normally self-employed and worked [ ] hours a week From: [DD] [MM] [YYYY]

To: [DD] [MM] [YYYY]

Accountant Details

Name:

Address:

Telephone Number: MOBILE

LANDLINE

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

Signature (**not** block letters)

Date: D D M M 2 0 Y Y

Official stamp

It is an offence not to provide relevant information about a claim for Respite Care Grant or to take part in a false application.

19. Are you attending or have you attended an Educational or training course outside the home in the last 18 months?

☐ Yes ☐ No

☐ Vocational Training Opportunities Scheme (VTOS) ☐ FÁS Training

Other:

Please specify

Hours: a week

20. If you work(ed) or attend(ed) an educational or training course outside the home for 15 hours or less a week in the last 18 months please have the following completed by your employer or training authority.

To be completed by Employer or Training Authority

I certify that _____ is/was employed by or in training with me for ____ hours a week since ____ ____ (D D) ____ ____ (M M) ____ ____ ____ ____ (Y Y Y Y)

Employment ceased (if applicable) ____ ____ (D D) ____ ____ (M M) ____ ____ ____ ____ (Y Y Y Y)

Employer or Training Authority Details

Name:

Address:

Telephone Number: MOBILE

LANDLINE

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

Signature (**not** block letters)

Official stamp

Date: ____ ____ (D D) ____ ____ (M M) 2 0 ____ ____ (Y Y Y Y)

It is an offence not to provide relevant information about a claim for Respite Care Grant or to take part in a false application.

Part 2 Details of person you are caring for

21. Their PPS No.:

22. Their surname:

23. Their first name(s):

24. Their date of birth:

D D M M Y Y Y Y

25. Is anyone else getting Carer's Allowance, Carer's Benefit or Domiciliary Care Allowance for them?

☐ Yes ☐ No

Only one Grant is paid for each person needing full-time care and attention.

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

27. Has anyone applied for the Respite Care Grant for the person named above?

☐ Yes ☐ No

28. Has the person being cared for worked outside the home in the last 18 months?

☐ Yes ☐ No

If 'Yes', please state:

Employer's name:

Address:

Type of work:

Hours: a day

Days: a week

29. In the past 18 months had this person any overnight stays in a Hospital/Convalescent home or similar type of institution?

☐ Yes ☐ No

If 'Yes', please state:

Hospital/Home name:

Address:

Date spent here: From:

To:

D D M M Y Y Y Y

Part 2 continued — Details of care you are providing

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

D D M M Y Y Y Y

31. Have you been or are you likely to be providing full-time care and attention for at least 6 months?

☐ Yes ☐ No

IMPORTANT: Respite Care Grant is paid only where the 6 month period of care includes the first Thursday in June. For more information, log on to www.welfare.ie.

32. Please give details of type of care (including personal care) you are providing for this person:

Hours: ☐☐ a day

Days: ☐ a week

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

The distance between the households: ☐☐ kilometres

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

☐ Yes ☐ No

If 'No', details of other direct link:

MOBILE

LANDLINE

Is the above address a full-time residential care facility (for example, Nursing Home)?

☐ Yes ☐ No

Part 3 Check if you qualify for Respite Care Grant

Are you working more than 15 hours per week outside the home?

☐ Yes ☐ No

Are you getting Jobseeker's Benefit or Jobseeker's Allowance?

☐ Yes ☐ No

Are you signing-on for Jobseeker's Credits?

☐ Yes ☐ No

If you answered 'Yes' to any of the above, you are not eligible for the Respite Care Grant. Please do not proceed with this claim.

Are you looking after the person(s) named in this form on a full-time basis?

☐ Yes ☐ No

Have you been or will you be providing full-time care and attention for at least 6 months?

☐ Yes ☐ No

The grant is only payable where the period of care includes the first Thursday in June.

If you answered 'No' to either of the above, you are not eligible for the Respite Care Grant. Please do not proceed with this claim.

To proceed with this application

* **Check you have given your PPS Number**
* **Check you have answered all the questions**
* **Check you have given the PPS Number of the person you are caring for**
* **Check you have signed the form (Part 1)**
* **Have the medical report (Part 4) signed by the person you are caring for and completed by their doctor.**

IMPORTANT! If any information is missing it will delay your application. Failure to answer any questions could cause a delay in your application

Warning: If you make a false statement or withhold information, you may get a fine, a prison term or both.

Send this completed application form to:

Respite Care Grant Section
Department of Social Protection
PO Box 10085
Dublin 2

Telephone: (01) 704 3240

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.

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Note to carer

Remember!

You do **not** need to apply for the Respite Care Grant if on the first Thursday in June of the year, in respect of which you are claiming, you or anyone else, is getting Carer's Allowance, Carer's Benefit, Domiciliary Care Allowance or Prescribed Relative Allowance for caring for this person.

The Respite Care Grant is paid automatically to anyone in these circumstances.

The following medical report is in two parts. **Have Section A completed by the person being cared for**. If the person being cared for cannot complete this form, it should be filled in for them and signed by a witness.

You must then pass the medical report to the doctor of the person being cared for. **The doctor must complete Section B, questions 1-11 inclusive**. As this is quite detailed, the doctor is unlikely to be able to complete the form immediately. You may both agree a suitable time for you to collect it. The doctor may decide to return the form to you in a sealed envelope, for reasons of medical confidentiality.

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

Social Welfare Services
Med Rpt RCG 1

Medical Report for
Respite Care Grant

Part 4 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 Respite Care Grant.

I understand that I may need to attend a medical exam from time to time and that my right to care under the Respite Care Grant scheme may be reviewed at any time.

Signature (**not** block letters)

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

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.

Signature (**not** block letters)

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

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 Respite Care Grant 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 Respite Care Grant 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 **Respite Care Grant Section** at (01) 704 3240

Note:

The carer should already have filled Parts 1 and 2 of the application form. The person being cared for must have completed Section A of this medical report.

THE COMPLETED MEDICAL REPORT FORM SHOULD BE RETURNED BY THE DOCTOR TO THE CARER WHO WILL SEND IT, ALONG WITH HIS/HER APPLICATION FORM, TO THE RESPITE CARE GRANT SECTION.

Part 4 Medical Report

Section B

1. Patient details

Surname:

First name:

Address:

Date of birth:

D D M M Y Y Y Y

PPS No.:

Mobile telephone No.:

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

2. Your patient since:

D D M M Y Y Y Y

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

4. ICD10 Code(s):

5. Date condition started:

D D M M Y Y Y Y

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

☐ less than 3 months ☐ 3-6 months ☐ 6-12 months

☐ 12-24 months ☐ indefinitely

Part 4 Medical Report

7. Please give:

Medical history

Surgical/Obstetrical history

Hospital admissions

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

Please attach any relevant reports/results of investigations.

Additional Information:

Part 4 Medical Report

Ability/Disability Profile:

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

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

11. A Medical Assessment by one of the Department's Medical Assessors may be required to determine eligibility.

Is your patient fit to attend a medical assessment? ☐ Yes ☐ No

If 'No', give details here:

Doctor's name:

DSP panel number: **IMC number:**

Address:

Doctor's Signature (**not** block letters)

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

Doctor's official stamp

For Official use Only

(i) **Eligible for Respite Care Grant:** ☐

(ii) **Review:**

(iii) **DNRA:** ☐

(iv) **Not eligible for Respite Care Grant:** ☐

Give reasons:

Signed _____ **Medical Assessor**

Date: ☐☐ ☐☐ 2 0 ☐☐

D D M M Y Y Y Y

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