

Application form for Domiciliary Care Allowance

Social Welfare Services

Dom Care 1

Data Classification R



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

How to complete this application form.

- 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.

Applicant: Should complete **Parts 1 to 5.**

G.P./Specialist: The child's G.P./Specialist should complete **Parts 6 and 7.**

To qualify for Domiciliary Care Allowance the child must have a severe* disability that requires ongoing care and attention substantially* over and above the care and attention usually required by a child of the same age and is likely to last for at least one year and:

- Be aged under 16 (at 16, the child can apply for a Disability Allowance).
- Live at home with the person claiming the allowance for five or more days a week.
- Be ordinarily resident in the State. This means that the child has to live in the Republic of Ireland and only leaves Ireland for holidays.

In addition, the person claiming the allowance for the child must:

- Provide for the care of the child.
- Be habitually resident in the State. As above, the person claiming the payment must normally live in the Republic of Ireland.

Please let us know your mobile phone number and we will text you right away confirming that we received your application.

Note: If your child has a pervasive developmental disorder (PDD), e.g. Autism Spectrum Disorder, you may wish to have the medical professional or specialist dealing with your child complete an additional medical form **Dom Care 3** available on www.welfare.ie, from your local Intreo Centre, Social Welfare Office or Citizens Information Centre. The complete form will detail your child's conditions and any specific care needs the child might have as a result of their disability and will assist the Department's Medical Assessor in forming an opinion on eligibility.

If you need any help to complete this form, please contact your local Intreo Centre, Social Welfare Office or Citizens Information Centre.
For more information, log on to www.welfare.ie.

*The definitions used for terms such as severe or substantial in this qualifying condition are detailed in the DCA Medical Guidelines used by the Department in assessing applications for DCA. For more information, log onto www.welfare.ie.

12. Child's PPS No.:

13. Child's Surname:

14. Child's First name(s):

15. Child's date of birth?
D D M M Y Y Y Y

16. Relationship to you:

17. Address (if different from yours):

18. Are you currently getting Child Benefit in respect of your child?
 Yes No

19. From what date has additional* care been required for your child?

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* Additional means care substantially in excess of that normally needed by a child of this age. Domiciliary Care Allowance is normally paid from the month after you first apply.

If you did not make an application from the date the additional care was first required and wish to apply for backdating of the allowance, please state the reasons you delayed in applying:

20. Does your child usually stay overnight in a special school/institution at any time during the year?
 Yes No

If 'Yes', please state:

Name of school/institution:

Location/address:

Average number of nights per week they stay overnight in this school/institution:
 a week



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

Financial Institution

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

Name of financial institution:

Address of financial institution:

Sort code:

Account number:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Name(s) of account holder(s):
 Name 1:

Name 2 (if any):

Post Office

Please enter below the name and address of the post office where you wish to collect your payment.

Post office name and address:



This section allows you to tell us about the extra care your child needs compared with a child of the same age without the same disability. We understand that it might be hard to answer some of these questions but please give us as much information as you can in support of your application.

If you need more room feel free to use another sheet of paper. It will help us if you write the heading and number at the top of the page (for example: 4.1.1. Mobility). Don't forget to attach the page to this form and put your name and Personal Public Service Number (PPS No.) on the top of each page.

4.1.1 Mobility - compared to a child of the same age

Can your child walk and move around like other children of the same age? Yes No Does not apply

Can your child safely climb stairs without help? Yes No Does not apply

Does your child need to be lifted, or given assistance to be transferred to or from:

The bed Yes No Does not apply

A chair or wheelchair Yes No Does not apply

The toilet, bath or shower Yes No Does not apply

If your child has problems with mobility, please describe what help your child needs.

Does your child have any problem with balance or co-ordination? Yes No

If 'Yes', describe your child's difficulties. Is this all the time or sometimes? How do you help them?



4.1.2 Personal Care -

Tell us what help your child needs in each of the following areas compared to a child of the same age without their disability.

- Can your child get out of bed safely on his/her own? Yes No Does not apply
- Can your child dress him or herself? Yes No Does not apply
- Can your child manage buttons and zips? Yes No Does not apply
- Can your child wash their face, hands and teeth? Yes No Does not apply
- Can your child shower or bath themselves without your help? Yes No Does not apply

If you answered No to any of the above, outline below the level of help your child needs for each area and how often you provide this each day.

- Does your child need help to use the toilet? Yes No Does not apply
- Does your child have any problems with wetting or soiling? Yes No Does not apply
- Does your child need to wear nappies, pull ups or pads? Yes No Does not apply

If you answered Yes to any of these, please describe the difficulties your child has with toileting and how much help your child needs.



4.1.3 Feeding/Diet - compared to a child of the same age

- Does your child need help or encouragement to eat or drink? Yes No
- Does your child need a special diet? Yes No
- Does he or she only eat certain food as a result of their disability? Yes No
- Does your child have food allergies? Yes No
- Do you have to control the food intake of your child? Yes No

If you answered Yes for any of the above, please describe your child's difficulties and the level of help they need.

4.1.4 Education/Schooling -

Does not apply (not school age)

Does your child attend:

- Preschool
- Mainstream School
- Home tuition/home schooling
- Special Unit within Mainstream school
- Special school for children with special needs

Does your child only attend school for part of the normal school day? Yes No

Has your child been excluded from any of the above as a result of their disability? Yes No

Does your child need extra help at school? Yes No

Does your child currently have access to a special needs assistant (SNA)? Yes No

Has your child ever been recommended for a special needs assistant (SNA) or had one in the past? Yes No

Has your child ever been recommended for assistive technology? Yes No

Does your child attend resource hours? Yes No

Does your child attend learning support? Yes No

Has your child had any issues at school that meant you had to attend? Yes No

Have you had to take your child home from school early on regular occasions for any reason? Yes No

Does your child have access to a visiting teacher for the visual or hearing impaired? Yes No



Please give details of the additional educational needs or supports your child requires.

4.1.5 Sleeping - compared to a child of the same age

Does your child generally sleep well most nights? Yes No

If No give us details such as how many times your child wakes up during the night. How often does this happen? Is there anything you need to do for them?

4.1.5 Sleeping, support needs at night frequency:

	Rarely/never	1 to 3 times a month	1 to 3 times a week	Most nights
Child wakes, settles quickly (< 15 mins)				
Child wakes, takes 15 mins to hour to settle				
Child wakes, takes longer than hour to settle				
Child wakes more than once a night (specify how often)				

Additional details you may wish to give:



4.1.6 Communication - compared to a child of the same age

Can your child hear normally? Yes No

Are your child's speech, language and communication skills as you would expect for a child the same age? Yes No

Does your child understand what you say to them and the words/language used? Yes No

Does your child understand facial expressions, body language etc.? Yes No

Can your child tell you when they are not well? Yes No

If you answered No to any of the above please describe the issues your child has and any help you have to give them.

4.1.7 Social Skills - compared to a child of the same age

Does your child display appropriate problem solving skills for their age? Yes No

Does your child make decisions in an age-appropriate way? Yes No

Does your child cope well with any changes in their routine? Yes No

Can your child amuse themselves? Yes No

If you answered No to any of the above, please describe what happens and any effect this has on you and your family.

Do you need to spend more time preparing your child before they leave the house, compared to other children of the same age? Yes No

Does your child get fixated on certain things? Yes No



Does your child need assistance to look after personal belongings?

 Yes

 No

Does your child like to be on their own?

 Yes

 No

Does your child have difficulty playing or mixing with other children?

 Yes

 No

Does your child have difficulty participating in events?

 Yes

 No

If you answered Yes to any of the above, please describe what happens and any effect this has on you and your family.

4.1.8 Behaviour - compared to a child of the same age

Do they display any high risk behaviours that require intervention from others to protect them from injuring themselves or others?

 Yes

 No

Is your child regularly irritable/prone to outbursts and difficult to calm down?

 Yes

 No

Does your child appear to be significantly depressed or anxious or suffer panic attacks?

 Yes

 No

Does your child run away from home/school/social gatherings?

 Yes

 No

Is your child ever aggressive to others (e.g. shouting, biting or kicking etc.) to an unusual degree for their age?

 Yes

 No

Does your child show unusual/obsessive/repetitive or withdrawn behaviours?

 Yes

 No

Do you need to lock household items away (e.g. matches, cleaning fluids, knives etc.)?

 Yes

 No

If you answered Yes to any of the above, please describe what is involved, how often this happens and the level of help your child needs and how this affects family life.



4.1.9 Safety -

Does your child have any dangerous habits or obsessions (e.g. fire starting, fascination with water, not responding when in dangerous situations)? Yes No

Does your child put foreign objects such as stones, twigs etc. in his/her mouth, ears, nose regularly? Yes No

Does your child have poor comprehension or perception of road safety skills (for example would run across the road without looking)? Yes No

Does your child have any self-harming behaviours (for example hair pulling, head banging, hand biting etc.)? Yes No

Have you made any changes to your home or car to make it safe for your child? Yes No

Is your child a flight risk? Yes No

If you answered Yes for any of the above or if there are any other safety issues, please describe what is involved, how often it happens and the level of extra help or supervision your child needs as a result.

4.1.10 Sensory issues -

Does your child get distressed by sights/noises/smells etc. that do not bother other people and which can limit places that they can go? Yes No

Does your child find it difficult to function or communicate when they are experiencing sensory overload? Yes No

Is your child's clothing restricted because they cannot tolerate certain fabrics on their skin? Yes No

If you answered Yes for any of the above or if your child has any other sensory issues, please describe what is involved, how often it happens and the level of extra help or supervision your child needs as a result.



4.1.11 Additional Needs -

Please detail any additional care needs that your child has and which you provide, including how often and for how long.

Examples might include:

- Use of specialist equipment.
- Techniques to help breathing.
- Special feeding arrangements.
- Dialysis.
- Dressing wounds.
- Stoma care requirements.
- Preparation of and/or administration of medication.
- Special transport arrangements.

4.1.12 Other issues -

Does your child's disability mean that it is difficult to arrange child care?

 Yes No

Does it prevent your family from going out together?

 Yes No

Please describe how your child's disability affects family life or other family members.

Is there any other additional information you wish to provide:



Is your child attending or waiting for an appointment for any of the following. Please print the word 'Yes' in the "waiting on appointment" or "attending therapy" columns.

Service	Waiting on appointment	Attending therapy	Date Referred			Reports available
Speech and Language	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational Therapy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychology	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Psychiatry	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physiotherapy	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Paediatrician	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital Consultant	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dietician	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Optician	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Audiologist	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Behavioural Support	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Worker	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Public Health Physician	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	2 0 <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

IF THE CHILD IS ATTENDING ANY OF THE ABOVE SERVICES, PLEASE ENCLOSE THE RELEVANT REPORTS IF AVAILABLE. IF AN "ASSESSMENT OF NEED" HAS BEEN CARRIED UNDER THE DISABILITY ACT 2005, PLEASE ATTACH A COPY.

Send this completed application form and all relevant reports to:

Domiciliary Care Allowance Section
 Social Welfare Services
 Department of Social Protection
 College Road
 Sligo

Data Protection Statement

The Department of Social Protection will treat all information and personal data you give us as confidential. However, it should be noted that information may be exchanged with other Government Departments / Agencies in accordance with the law.

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



Part 5

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 Domiciliary Care Allowance.

Your doctor should then complete Part 6 and 7 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.

Authorisation

I permit my doctor to provide you, the Department of Social Protection, with medical information that you may need for this application for Domiciliary Care Allowance.

If you cannot sign your name, make a mark, such as an X, and have a witness sign their name beside it.

Signature (not block letters)

Date:
D D M M Y Y Y Y

Part 6

To be completed by the child's G.P./Specialist

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess their eligibility for Domiciliary Care Allowance, please complete the medical report below. The medical information provided will be reviewed by our medical assessors and will be treated in strictest confidence.

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's details

Surname:

First name:

Address:

Date of birth:

D D M M Y Y Y Y

2. Your patient since:

D D M M Y Y Y Y

3. Diagnosis (use BLOCK LETTERS):

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 12 months 12-24 months
 24-48 months indefinitely



7. Please give:

Medical History

Surgical History

Clinical Findings

Hospital admissions

Date of most recent admission:

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D D M M Y Y Y Y

Date of discharge:

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

D D M M Y Y Y Y

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

Attending a specialist

Details:

On Medication

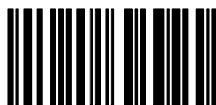
Details:

Other treatment

Details:

Please attach any relevant reports.

Additional Information:



Indicate the degree to which the child's condition has affected their ability in each of the following areas.

Should ability in any area be inappropriate to the age of the child, please tick N/A.

Area	Ability level					
	Normal	Mild	Moderate	Severe	Profound	N/A
Mental health						
Behaviour						
Intelligence						
Learning						
Consciousness/Seizures						
Speech						
Communication						
Social Skills						
Vision						
Hearing						
Sensory issues						
Feeding/Diet						
Sleeping						
Washing						
Dressing						
Continence						
Mobility						
Balance/Co-Ordination						
Manual Dexterity						
Reaching/Lifting/Carrying						
Sitting/Standing						
Climbing Stairs						
Bend/Kneel/Squatting						
Fine Motor Skills (age appropriate)						
Gross Motor Skills (age appropriate)						





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