Social Welfare Services
DA 1

Data Classification R

Application form for
Disability Allowance

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

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.

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

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

Fill in **Parts 1 to 6** and **10**. You should sign **Part 11** 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:

Fill in **Part 1 to 8** and **10**. You should sign **Part 11** 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 12**. 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 Citizens Information Centre, your local Intreo Centre or your local Social Welfare Office.

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 T

2. Title: (insert an 'X' or specify) Mr. ☐ Mrs. ☒ Ms. ☐ Other

3. Surname: MURPHY

4. First name(s): MAUREEN

5. Your first name(s) as appears on your birth certificate: MARY

6. Birth surname: MCDERMOTT

7. Your date of birth: 28 02 1970

D D M M Y Y Y Y

8. Your mother's birth surname: KELLY

Contact Details

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

County DONEGAL Postcode

10. Your telephone number: ONE NUMBER PER BOX

MOBILE

ONE NUMBER PER BOX

LANDLINE

11. Your email address: ONE CHARACTER PER BOX

SAMPLE

Application form for

Disability Allowance

1642642B

Social Welfare Services
DA 1

Data Classification R

Part 1 — Your own details (person who is disabled or ill)

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(s) as appears on your birth certificate:**
6. **Birth surname:**
7. **Your date of birth:** D D M M Y Y Y Y
8. **Your mother's birth surname:**

Contact Details

9. **Your address:**

County Postcode

10. **Your telephone number:** MOBILE

LANDLINE

11. **Your email address:**

Declaration

I declare that the information given by me on this form is truthful and complete. I understand that if any of the information I provide is untrue or misleading or if I fail to disclose any relevant information, that I will be required to repay any payment I receive from the Department and that I may be prosecuted. I undertake to immediately advise the Department of any change in my circumstances which may affect my continued entitlement.

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

Date: D D M M 2 0 Y Y

Signature (**not** block letters)

Date: D D M M 2 0 Y Y

Signature of witness (**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.

21D40862

Part 1 continued — Your own details (person who is disabled or ill)

12. Are you?

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Cohabiting
- ☐ In a Civil Partnership
- ☐ A surviving Civil Partner
- ☐ A former Civil Partner (you were in a Civil Partnership that has since been dissolved)

13. If you are married, in a civil partnership 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:

Part 2 — Your work and claim details

Disability Allowance is a means tested payment. You are legally obliged to declare all your means which include money in cash or in a financial institution, savings, shares, bonds, funds, property (other than your own home), foreign pensions etc. Please include written evidence such as statements and payslips with your application. Failure to do so could result in a delay in processing your application.

You must also declare the means of your spouse, civil partner or cohabitant even if you are not claiming an increase for a qualified adult.

15. Are you employed at present? ☐ Yes ☐ No

If 'Yes', please state:

Employer's name:

Employer's address:

Type of work:

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

Gross weekly earnings: € ,. a week

Please attach 3 of your most recent payslips.

Part 2 continued — Your work and claim details

16. Are you getting a social security payment from another country?

☐ Yes ☐ No

If 'Yes', 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 and also provide a 6 month bank statement for the account to which this payment is made.

17. Are you getting any other pension or allowance from the Republic of Ireland or from another country?

☐ Yes ☐ No

If 'Yes', 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 and also provide a 6 month bank statement for the account to which this payment is made.

18. Are you or have you been self-employed?

☐ Yes ☐ No

If 'Yes', please state:

Type of work you do/did:

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.

19(a). Do you own, share in the ownership, work or rent a farm or land?

☐ Yes ☐ No

If 'Yes', please state:

Size of farm or land: acres

Herd or flock number:

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

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

19(b). If your farm or land is let, please state net yearly income from letting:

Net yearly income: € , .

Part 2 continued — Your work and claim details

20(a). Are you 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: D D M M Y Y Y Y
Community employment:	☐ Yes	☐ No	
Rural Social Scheme:	☐ Yes	☐ No	
Area-Based Initiative:	☐ Yes	☐ No	
Back to Work Scheme:	☐ Yes	☐ No	
Vocational Training Opportunities Scheme:	☐ Yes	☐ No	
Back to Education Allowance:	☐ Yes	☐ No	
FÁS course or schemes:	☐ Yes	☐ No	
School or college:	☐ Yes	☐ No	
Other course or scheme:	☐ Yes	☐ No	

If 'Yes', please state:

Name of course or scheme:

Date you started: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

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

€ ,. a week

21. Do you own stocks, shares (including shares in a creamery or Co-op, annuities, bonds, insurance policies) or investments in the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', please state:

Name of company:

Number of shares held: ,

Their value: € ,.

Please attach a statement to show details and current market value.

Part 2 continued — Your work and claim details

22. Do you have savings or accounts in a bank, post office, building society, credit union or any other financial institution in the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', please state:

Financial Institution 1

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this account a joint account? ☐ Yes ☐ No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Financial Institution 2

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this account a joint account? ☐ Yes ☐ No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Please attach an original statement for each account, showing transactions for the last 6 months.

If you have any other accounts you must give details of them to this Department on a separate sheet of paper.

Part 2 continued — Your work and claim details

23. Do you own or share in the ownership of 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 19.

Current market value: € ,. .

Rent from this property: € ,. a week

Please provide a valuation from an authorised auctioneer or valuer.

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.

24. Are you receiving maintenance? ☐ Yes ☐ No

If 'Yes', please state:

Amount: € ,. a week

Please provide a copy of the maintenance agreement.

If you are receiving maintenance, please state the amount of mortgage or rent that you pay a week:

Amount: € ,. a week

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

25(a). Have you made or do you intend to make a claim for compensation?

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

Part 2 continued — Your work and claim details

25(b). Do you expect to receive any additional income or money in the coming 12 months from any other source(s) (that is for example a claim for compensation arising out of an accident/injury, sale of property, etc.)?

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

26. Do you have any other income from the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

27. 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:

28. Did you recently sell your home to buy another? ☐ Yes ☐ No

If 'Yes', please outline the circumstances in the space provided and attach supporting documentary evidence from your solicitors regarding the financial transaction.

Part 3 Habitual Residence Condition

29. What country were you born in?

30. What is your nationality?

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

D D M M Y Y Y Y

32. Have you lived outside the Republic of Ireland for any period longer than three months within the last five years?

☐ Yes ☐ No

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

Country 1

Country:

From:

To:

D D M M Y Y Y Y

Why you lived there:

Country 2

Country:

From:

To:

D D M M Y Y Y Y

Why you lived there:

For official use only

HRC satisfied ☐ HRC not satisfied ☐ HRC1 issued ☐

Part 4 Your payment details

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:

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:

If you are unable to collect or cash your payment at the post office and you want someone else (known as an agent) to do so for you, please complete the following:

Your agent's name:

Your agent's address:

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

Your Signature (**not** block letters)

I agree to act as agent for the person named in Part 1 and I am aware of my obligations. For more information, log on to www.welfare.ie.

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

Signature of agent (**not** block letters)

Part 5 Details of your qualified child(ren)

33. Do you wish to apply for qualified child(ren)?

☐ Yes ☐ No

If 'Yes', how many children do you wish to claim for?

☐☐ under age 18

☐☐ age 18 - 22 in full-time education

Do they live with you? ☐ Yes ☐ No

Please state child's:

Child 1

Surname:

First name(s):

PPS No.:

Date of birth: D D M M Y Y Y Y

Child 2

Surname:

First name(s):

PPS No.:

Date of birth: D D M M Y Y Y Y

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

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

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

Part 6 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**.

34. Do you wish to claim a Living Alone Increase?

☐ 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 2 allowances:

- **Electricity or Gas Allowance**
- **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.

35. 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.

36. The following people live with me:

Person 1

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed (including farming)

If so, state weekly amount: € , . a week

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: € , . a week

Part 6 continued Other payments

Person 2

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed (including farming)

If so, state weekly amount: € , . a week

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: € , . a week

Person 3

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed (including farming)

If so, state weekly amount: € , . a week

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: € , . a week

Part 6 continued — Other payments

Person 4

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed (including farming)

If so, state weekly amount: € ☐☐☐,☐☐☐.☐☐ a week

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: € ☐☐☐,☐☐☐.☐☐ a week

Extra benefits

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

Part 7 — Your spouse's, civil partner's or cohabitant's details

37. Their PPS No.:

38. Title: (insert an 'X' or specify) Mr. ☐ Mrs. ☐ Ms. ☐ Other

39. Their surname:

40. Their first name(s):

41. Their birth surname:

42. Their date of birth: D D M M Y Y Y Y

43. Their mother's birth surname:

44. Their address:

Only answer this question if you are married or in a civil partnership and do not live together.

Part 8 Your spouse's, civil partner's or cohabitant'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.

45. Do you wish to claim an increase for your spouse, civil partner or cohabitant?

☐ Yes ☐ No

46. Are they employed at present?

☐ Yes ☐ No

If 'Yes', please state:

Their employer's name:

Their employer's address:

Type of work:

Their gross weekly earnings: € , . a week

Please attach 3 of their most recent payslips.

Number of days worked: a week

47. Are they getting a social security payment from another country?

☐ Yes ☐ No

If 'Yes', 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 and also provide a 6 month bank statement for the account to which this payment is made.

Part 8 continued

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

48. Are they getting any other pension or allowance from the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', 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 and also provide a 6 month bank statement for the account to which this payment is made.

49. Are they or have they been self-employed?

☐ Yes ☐ No

If 'Yes', please state:

Type of work they do/did:

Dates of self-employment: From:

To:

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.

50(a). Do they own, share in the ownership, work or rent a farm or land?

☐ Yes ☐ No

If 'Yes', please state:

Size of farm or land: acres

Herd or flock number:

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

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

50(b). If their farm or land is let, please state net yearly income from letting:

Net yearly income: € , .

Part 8 continued

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

51(a). Are they 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 you insert an X in the Yes box.

			Date they started: D D M M Y Y Y Y
Community employment:	☐ Yes	☐ No	
Rural Social Scheme:	☐ Yes	☐ No	
Area-Based Initiative:	☐ Yes	☐ No	
Back to Work Scheme:	☐ Yes	☐ No	
Vocational Training Opportunities Scheme:	☐ Yes	☐ No	
Back to Education Allowance:	☐ Yes	☐ No	
FÁS course or schemes:	☐ Yes	☐ No	
School or college:	☐ Yes	☐ No	
Other course or scheme:	☐ Yes	☐ No	

If 'Yes', please state:

Name of course or scheme:

Date they started: From: D D M M Y Y Y Y

To: D D M M Y Y Y Y

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

€ , . a week

52. Do they own stocks, shares (including shares in a creamery or Co-op, annuities, bonds, insurance policies) or investments in the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', please state:

Name of company:

Number of shares held: ,

Total value of these shares: € , .

Please attach a statement to show details and current market value.

Part 8 continued

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

53. Do they have savings or accounts in a bank, post office, building society, credit union or any other financial institution in the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', please state:

Financial Institution 1

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this account a joint account? ☐ Yes ☐ No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Financial Institution 2

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Current balance: € , .

Is this account a joint account? ☐ Yes ☐ No

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Please attach an original statement for each account, showing transactions for the last 6 months.

If they have any other accounts you must give details of them to this Department on a separate sheet of paper.

Part 8 continued

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

54. Do they own or share in the ownership of property apart from their 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 50.

Current market value: € ,. .

Rent from this property: € ,. a week

Please provide a valuation from an authorised auctioneer or valuer.

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 they have.

55. Are they receiving maintenance? ☐ Yes ☐ No

If 'Yes', please state:

Amount: € ,. a week

Please provide a copy of the maintenance agreement.

56. Do they expect to receive any additional income or money in the coming 12 months?

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

Part 8 continued

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

57. Do they have any other income from the Republic of Ireland or another country?

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

58. 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:

59. Have they moved from their home? ☐ Yes ☐ No

If 'Yes', please outline the circumstances in the space provided. If their home is rented, occupied by other people or otherwise being used, please give details:

60. Did they recently sell their home to buy another? ☐ Yes ☐ No

If 'Yes', please outline the circumstances in the space provided and attach supporting documentary evidence from their solicitors regarding the financial transaction.

Part 9 Checklist

Have you enclosed the following?

— **You 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 all financial institutions showing the last 6 months transactions (internet printouts are not generally accepted)**
(if you or your spouse, civil partner or cohabitant have money or investments 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 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 you are claiming for Fuel Allowance, please make sure that you have you fully completed Question 35 and 36.

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.

Make sure that you supply all information required in this form.

Please remember your claim cannot be processed without the medical part being completed and decision on your claim will be delayed.

Please remember to sign the Declaration in Part 1.

If you have any difficulty in filling in this form, please contact your local Citizens Information Centre, your local Intreo Centre or your local Social Welfare Office.

Part 9 continued Checklist

Send this completed application form to:

Disability Allowance Section
Social Welfare Services
Government Buildings
Ballinalee Road
Longford

Telephone: (043) 334 0000
LoCall: 1890 92 77 70
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.

Part 9 continued Checklist

Please also fill in Part 10 and 11 and then give this form to your doctor who will complete Part 12 (Medical Report).

The Department's doctor may be asked to provide us with an opinion as to whether you satisfy the medical eligibility for Disability Allowance based on the information you and your doctor give about your medical condition. A Deciding Officer may have regard to this opinion in deciding whether you satisfy the medical eligibility for Disability Allowance. It is important therefore that you enclose with your application full details of your medical condition and how it affects your everyday life and ability to work so as to ensure that all relevant matters are taken into account at the earliest opportunity. A failure to do so could result in a decision on your application being significantly delayed.

In addition to your doctor completing Part 12 you should request them to enclose copies of any recent reports from specialists (such as consultants, psychiatrists, psychologists, physiotherapists, counsellors), any results of tests and any other information that your doctor thinks is relevant. This will ensure that we have a full picture of your medical condition when we make a decision on your claim.

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 10

Your education and work history and how your medical condition affects the activities of your typical day

One of the conditions for receiving disability allowance is that you must have an injury, disease or other disability AND, as a result of this disability, you must be substantially restricted in undertaking work that would otherwise be suitable for a person of your age, experience and qualifications.
In order to assess your medical eligibility we need you to give us some information about you, your medical condition and how it affects your daily life.

1(a). Are you still in education?

☐ Yes ☐ No

If 'No', please state the age when you finished your last course:

☐☐

1(b). Please state your level of education:

Primary Education:	☐ Yes	☐ No
Inter/Junior Certificate:	☐ Yes	☐ No
Leaving Certificate:	☐ Yes	☐ No
Third Level:	☐ Yes	☐ No
Other:	☐ Yes	☐ No

If Yes to '**Other**', please give details of '**Other**' in the space provided:

1(c). Please summarise any training or apprenticeships you completed and give dates they started and were completed:

Part 10 continued

Your education and work history and how your medical condition affects the activities of your typical day

1(d). Please summarise your work history including self employment (including farming) and give dates you started and finished:

2(a). Describe how your condition affects your activities during a typical day, as outlined below. If necessary, please use an additional sheet of paper.

Is your Mental Health affected?

For example, impaired attention, concentration, poor memory and fatigue. Coping with pressure and interacting with people. Disturbed sleep pattern.

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

2(b). Is your Physical Health affected?

For example, standing, sitting, bending, squatting, lifting/carrying, reaching, climbing stairs or ladders, using public transport.

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

Part 10 continued

Your education and work history and how your medical condition affects the activities of your typical day

2(c). Is your home and family care affected (for example, housework, shopping, cooking or DIY):

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

2(d). Is your manual dexterity affected (for example, picking up small items, writing or using a computer):

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

2(e). Is your communication and sensory affected (for example, speech/hearing/seeing):

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

2(f). Are your hobbies and leisure affected (for example, sports, reading or watching TV):

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

Part 10 continued

Your education and work history and how your medical condition affects the activities of your typical day

2(g). Please provide an outline of your activities during a typical day and any other relevant information?

2(h). How often do you visit your doctor?

- Weekly ☐
- Monthly ☐
- Less often ☐

2(i). Are you currently on medication?

☐ Yes ☐ No

If 'Yes', please give details in the space provided:

The information provided will be treated in the strictest confidence

Before submitting this application please ensure that you supply all information requested in this form and that you and your Doctor submit comprehensive information on your medical condition. This will result in your claim being processed in a timely manner and allow for a better quality decision on your claim.

Part 11 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 12 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 Protection, 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 12 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 12 continued — Medical report by your doctor

1. Patient details **(please use Block capitals)**

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

Occupation:

2(a). Your patient since:

D D M M Y Y Y Y

2(b). How often does the patient visit your surgery? ☐ Weekly ☐ Monthly ☐ Less often

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

7. Please give:

Medical history

Surgical/Obstetrical history

Attach relevant reports/test results/referrals

Part 12 continued Medical report by your doctor

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:

Part 12 continued — Medical report by your doctor

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:

12. Is the customer suitable for work/training for rehabilitative purposes?

☐ Yes ☐ No

This section is only relevant to Companion Free Travel Pass applications

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

☐ Yes ☐ No

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

☐ Yes ☐ No

Part 12 continued — Medical report by your doctor

Doctor's name:

DSP panel number:

IMC number:

Address:

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

Doctor's official stamp

Date: D D M M Y Y Y Y (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: | | | | | 2 | 0 | | |
D D M M Y Y Y Y

Data Protection Statement

Personal data is required to determine eligibility for payments and services, administered for Ireland's social protection system. It may be shared with other Government Departments/Agencies where provided for by law. Data protection policy available at www.welfare.ie/dataprotection or hard copy.

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