Application form for

Disability Allowance

Social Welfare Services
DA1
Data Classification R

What is Disability Allowance?

Disability Allowance is a means tested payment for people with a specified disability whose household income falls below certain levels.

How do I qualify?

To get Disability Allowance you must:

- have an injury, disease, physical or mental disability, that has continued or may be expected to continue for at least one year;
- as a result of this disability, medical condition, illness or injury, you must be determined by a Deciding Officer of the department as being substantially restricted in undertaking work that would otherwise be suitable for a person of your age, experience and qualifications; and
- be aged between 16 and 66, satisfy a means test and be habitually resident in the State.

What do I need to complete this application form?

- fill in Parts 1 to 7 as they apply to you and your household;
- complete Part 8 checklist and make sure you have all the information and documents listed;
- complete Part 9 outlining your education, work history and how your medical condition affects your daily life;
- sign the declaration in Part 10;
- sign Part 11a confirming that you allow your doctor to give us the medical information needed to decide if you qualify;
- you will also need to ask your doctor to complete the medical report contained in Part 11b.

How to complete this application form?

- there is an example on the back of this page that can be used as a guide to fill in this form;
- write with a black ballpoint pen;
- use BLOCK LETTERS and place an X in the relevant boxes; and
- answer all the questions.

How do I apply?

Send this completed form to:

Disability Allowance Section
Social Welfare Services
Government Buildings
Ballinalee Road
Longford
N39 E4E0

How can I get help and further information?

If you need any help to complete this form, please contact the Disability Allowance Section on (043) 334 0000, or 0818 927770, or your local Intreo Centre, Social Welfare Office or any Citizens Information Centre. You can find the name and address of your local Intreo Centre or Social Welfare Office by visiting **www.gov.ie/intreocentres**

For more information visit **www.gov.ie/da**

How to fill in this form

To help us to process your application write letters and numbers clearly and use one box for each. Please see examples below.

1. Your PPS Number: 1 2 3 4 5 6 7 T

2. Title, insert an **X** or specify: Mr. ☐ Mrs. ☒ Ms. ☐ Other

3. Surname: MURPHY

4. First names: MAUREEN
MARY

5. Birth surname: MCDERMOTT

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

7. Your address: 1 NEW STREET
OLD TOWN
DONEGAL TOWN
County DONEGAL
Eircode C15A96V

8. Your mobile phone number: 0881234567

9. Your email address: MMURPHY@WELFARE.IE

10. 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)

11. If you are married, in a civil partnership or cohabiting, from what date? 01 01 1999
D D M M Y Y Y Y

12. Are you in full time education? ☒ Yes ☐ No

If **yes**, please provide details: DIPLOMA IN COMPUTER SCIENCE IN DCU

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Part 1 Your own details

1. Your PPS Number:

2. Title, insert an **X** or specify: Mr. ☐ Mrs. ☐ Ms. ☐ Other

3. Surname:

4. First names:

5. Birth surname:

6. Your date of birth: D D M M Y Y Y Y

7. Your address:

County

Eircode

8. Your mobile phone number:

9. Your email address:

10. 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)

11. If you are married, in a civil partnership or cohabiting, from what date? D D M M Y Y Y Y

12. Are you in full time education? ☐ Yes ☐ No

If **yes**, please provide details.

Part 2 Your partner's details

Note: If you have a spouse, civil partner or cohabitant, they will be referred to as your partner for the rest of this form to make it easy to fill out.

13. Their PPS Number:

14. Title, insert an **X** or specify: Mr. ☐ Mrs. ☐ Ms. ☐ Other

15. Their surname:

16. Their first names:

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

18. Their address:

County

Eircode

Part 3 Your and your partner's work and claim details

Disability Allowance is a means tested payment. You are legally obliged to declare all your means which includes for example, money in cash or in a financial institution, savings, shares, bonds, funds, foreign pensions, property other than your own home.
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 partner even if you are not claiming an increase for them.

If you have a partner please answer these questions and submit their payslips and financial documents where requested.

19. Are you or your partner employed?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No

If **yes**, please attach three recent payslips.

20. Are you or your partner in receipt of a social protection payment, pension or an allowance from Ireland or any other country?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If **yes**, please state:			
Who pays this payment, pension or allowance?				
The claim or reference number:				
Weekly amount:	€		€	

If **yes**, please attach the most recent payslips, statements or letters from the people who pay confirming the above amounts. Also provide three months bank statements for the accounts to which the payments are made.

21. Are you or your partner currently self-employed or have either of you been self-employed in the past?

		You		Partner	
		☐ Yes	☐ No	☐ Yes	☐ No
		If **yes**, please state:			
Business Name:					
Type of employment					
		Please supply the most recent set of accounts.			
Dates of self-employment	From:				
	To:				
		D D M M Y Y Y Y		D D M M Y Y Y Y	

If self-employment has stopped, please provide documents to show how and when it ended.

22. Do you or your partner own, share in the ownership, work, rent or let a farm or land?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If **yes**, please state:			
The net yearly income or rent from the farm or land:	€		€	

Note: Net yearly income is money made from the farm or land after deducting operating expenses. Please supply the most recent set of farm accounts. If the land is leased, please provide a copy of the lease agreement.

23. Are you or your partner taking part in any courses or any type of employment schemes?

		You		Partner	
		☐ Yes	☐ No	☐ Yes	☐ No
		If **yes**, please state:			
The name of the course or scheme:					
Course or scheme dates:	From:				
	To:				
		D D M M Y Y Y Y		D D M M Y Y Y Y	

What is the payment for doing this course or scheme per week:	€	€

Please provide a letter from the course or scheme providers detailing payments received.

24. Do you or your partner own stocks, shares, including shares in a creamery or Co-op, annuities, bonds, insurance policies or investments in Ireland or another country?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No

If **yes**, please attach up to date statements showing details and current market values.

25. Do you or your partner hold, or jointly hold, any savings or accounts in a post office, bank, building society, credit union or any other financial institution in Ireland or in another country?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No

If **yes**, please forward three recent months statements for each account held.

26. Do you or your partner own or share in the ownership of property apart from your home?
Note: Property is an apartment, business property, house or land other than that mentioned at question 22.

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
	If **yes**, please state:			
Address of property:				
Country:				
Postcode or Eircode:				

For all properties listed above, please provide a:

- copy of the rent or lease agreements;
- valuations from an authorised auctioneer or valuer for the properties; and
- recent statements from the lending institutions if mortgaged.

A separate sheet of paper can be used for details of any additional properties.

27. Are you or your partner receiving maintenance?

	You		Partner	
	☐ Yes	☐ No	☐ Yes	☐ No
If maintenance is received, please state the amount:				
Weekly amount:	€		€	
If an amount of mortgage or rent is paid, please state amount paid per week:				
Weekly amount:	€		€	

Please attach a copy of the maintenance agreement as well as a statement from the mortgage provider or a rent receipt from the agency or landlord.

28. Do you or your partner expect to receive any additional income or money in the coming 12 months from any other sources? For example, a claim for compensation arising out of an accident, injury, sale of property, pension lump sum or inheritance.

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No
If **yes**, please give details in the space below:			

If **yes**, please provide letter from your solicitor confirming status of compensation or inheritance payments.

29. Did you or your partner sell or transfer property, a business or your home in the last three years?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No
If **yes**, please outline the circumstances in the space below and attach documents from your solicitors regarding the financial transaction:			

30. Do you or your partner have any other income in Ireland or from another country?

You		Partner	
☐ Yes	☐ No	☐ Yes	☐ No
If **yes**, please give details in the space below:			

Part 4 Nationality and details of where you have lived

31. What country were you born in?

32. What is your nationality?

33. Have you lived outside of Ireland for any period longer than three months in the last five years?

☐ Yes ☐ No

If **yes**, please give details of where you lived below:

Country 1

Country:

From:

To:

D D M M Y Y Y Y

Why did you live there?

Country 2

Country:

From:

To:

D D M M Y Y Y Y

Why did you live there?

Part 5 Details of your children

An increase for a qualified child is payable for each child under 18 years of age who is normally resident with and/or is being maintained by you. This increase is also payable in respect of a child over the age of 18, who is in full-time education by day at a recognised school or college up to the end of the academic year in which they reach 22 years of age.

34. Do you wish to apply for an increase for qualified children?

☐ Yes ☐ No

Please provide details of your children which you wish to apply for below.

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

Child 1

Surname:

First names:

PPS Number:

Do they live with you? ☐ Yes ☐ No

Child 2

Surname:

First names:

PPS Number:

Do they live with you? ☐ Yes ☐ No

Child 3

Surname:

First names:

PPS Number:

Do they live with you? ☐ Yes ☐ No

Child 4

Surname:

First names:

PPS Number:

Do they live with you? ☐ Yes ☐ No

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

Part 6 Other payments

Living Alone Increase

35. Do you wish to claim a Living Alone Increase? ☐ Yes ☐ No

If **yes**, please state the 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 two allowances:

- Electricity or Gas Allowance.
- Free Television Licence.

If you qualify for Disability Allowance, the quickest way to apply for the Household Benefits Package is online at **MyWelfare.ie**

If you are unable to apply online, fill in the Household Benefits Package (HB1) application form. To get the HB1 application form, visit **www.gov.ie/householdpackage**

You can also get the HB1 application form from your local Intreo Centre, Social Welfare Office or any Citizens Information Centre. For more information, visit **www.gov.ie/householdpackage**

Fuel Allowance

Note: The Fuel Allowance is subject to your household make up. Only one person in a household can get this allowance.

36a. Do you wish to apply for Fuel Allowance? ☐ Yes ☐ No

36b. If yes, how do you wish to be paid? ☐ Weekly ☐ Lump sum

If you answered **yes** to Q36a, please answer Q37 otherwise leave blank.

37. The following people live with me:

Person 1

Surname:

First names:

PPS Number:

Person 2

Surname:

First names:

PPS Number:

Note: A separate sheet of paper can be used for details of other people living with you.

Part 7 Your payment details

Note: You can get your payment sent to your post office or to your financial institution. An account must be in your name or jointly held by you.

38. Where would you like to get your payment? Please complete one option below.

Financial Institution

Note: You will find the information requested below printed on statements from your financial institution.

Name of financial institution:

Bank Identifier Code (BIC):

International Bank Account Number (IBAN):

Names of account holders:

Name 1:

Name 2 if any:

Post Office

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

Post office name and address:

Agent

Note: 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 an agent for the person named in Part 1 and I am aware of my obligations. For more information, visit **www.gov.ie/appointagent**

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

Signature of agent, **not** block letters

If you are unable to manage your own financial affairs, you and your Doctor need to complete an additional form. Details contained in Part 10.

Part 8 Checklist

Failure to complete this application form in full or to provide the required additional information will result in delays in the processing of your application. Please use the checklist below to ensure that you have supplied all the required information with your application.

Remember your claim cannot be processed without the medical parts 9, 10 and 11 being completed.

Additional information	Relevant Question	Provided, Yes or No
Three recent payslips for you and your spouse, civil partner or cohabitant.	19	
Letter or payslip providing details of any social protection payment, pension, allowance or income you are in receipt of.	20	
If self-employment has stopped, please provide documents to show how and when it ended.	21	
Most recent set of business accounts.	21	
Most recent set of farm accounts.	22	
Copy of farm lease agreement.	22	
Letter from course or employment scheme provider, with details of any payments.	23	
Most recent statements of for example, pensions, retirement funds, investments, stocks, shares, insurance policies.	24	
Three months statements from all financial institutions where you or your spouse, civil partner or cohabitant have accounts.	25	
Details including current valuation, mortgage details, rental income for any properties owned, apart from your family home.	26	
Statement from lending agency or rent receipt from landlord if you are receiving maintenance and copy of maintenance agreement.	27	
Letter from your solicitor confirming status of compensation or inheritance payments.	28	
Documents from your solicitors detailing the sale, transfer of property, business or home in the last three years for you, your spouse, civil partner or cohabitant	29	
Letter from school or college if you are claiming for children aged between 18-22 who are in full time education.	34	
Certificates		
Birth and Marriage Certificates are only required if registered outside the state.		
Your birth certificate.		
Spouse, civil partner or cohabitant birth certificate.		
Marriage, civil partnership or civil union registration certificate.		
Children's birth certificates. They are not needed if you are already claiming Child Benefit for the children.		

Data Protection Statement

The Department of Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments and benefits. Personal data may be exchanged with other government departments and agencies where provided for by law. Our data protection policy is available at **www.gov.ie/dsp/privacystatement** or as hard copy.

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

Part 9

Your education and work history and how your disability, medical condition, illness or injury affects the activities of your typical day

One of the conditions for receiving disability allowance is that you must have a disability, medical condition, illness or injury. As a result of this disability, medical condition, illness or injury, you must be determined by a Deciding Officer of the department as being 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 disability, medical condition, illness or injury and how it affects your daily life.

Current occupation	
Date last worked:	Proposed date that you will return to work if known:

Previous work history. Type of work or job title.	Date from:	Date to:
1.		
2.		
3.		

Level of education:

Primary ☐ Secondary ☐ Third Level ☐ Other, for example, special school ☐

Please list below, further education and training courses:

Present disability, medical conditions, illness or injuries.
Provide details below of your current disabilities, medical conditions, illnesses or injuries including the date of onset and the date that treatment started:

Condition	Date of onset of condition	Date that treament started
1.		
2.		
3.		

Past medical conditions, operations and injuries
List below including month and year of diagnosis

Condition	Month and year of diagnosis
1.	
2.	
3.	
4.	
5.	

Your GP (doctor) details:

Name:

Address:

Currently attending specialists: No ☐ Yes ☐ If **yes** complete the following:

Names of specialists and their specialties.
List and attach copies of any specialist reports if available:

Month and year of most recent specialist appointments:	Month and year of future specialist and therapist appointments if known:
Month and year of recent operation or procedure:	Month and year of future operation procedure:

Investigations:.
Please provide details of any medical investigations and attach any relevant reports and results of the investigations:

If pregnant expected date of delivery (EDD):

Medication:
List below what you are prescribed and are currently taking together with the dosage and how many times a day. Or attach a copy of your recent prescriptions if available:

1.	5.
2.	6.
3.	7.
4.	8.

How does your disability, medical condition, illness or injury affect you in the following areas?

Physical health:

How far can you walk on level ground without needing to stop?	
Do you require mobility aids? For example, walking stick, crutch or wheelchair. No ☐ Yes ☐ If yes, specify:	
Can you climb stairs without assistance? No ☐ Yes ☐ If no, specify:	
Does your disability, medical condition, illness or injury affect sitting or standing? No ☐ Yes ☐ If yes, describe:	
Have you any difficulty with balance or co-ordination? No ☐ Yes ☐ If yes, describe:	
Have you any difficulty with the use of your hands? No ☐ Yes ☐ If yes, describe:	
Have you difficulty with lifting or carrying? No ☐ Yes ☐ If yes, describe:	

Mental Health:

Do you have any difficulty with your memory? No ☐ Yes ☐ If yes, describe:	
Do you have any difficulty with your concentration? For example, reading and watching TV. No ☐ Yes ☐ If yes, describe:	
Have you any difficulty learning new information? No ☐ Yes ☐ If yes, describe:	
Do you have difficulty sleeping? No ☐ Yes ☐ If yes, describe:	
Do you have difficulty interacting with people? No ☐ Yes ☐ If yes, describe:	
Have your leisure activities been affected by your illness or injury? No ☐ Yes ☐ If yes, describe:	

Activites of daily living (ADL):

Are the following activities of daily living affected by your disability, medical condition, illness or injury?

Showering No ☐ Yes ☐ If yes, specify:	
Dressing No ☐ Yes ☐ If yes, specify:	
Toileting No ☐ Yes ☐ If yes, specify:	
Housework or Cooking No ☐ Yes ☐ If yes, specify:	
Shopping No ☐ Yes ☐ If yes, specify:	
Care of Family No ☐ Yes ☐ If yes, specify:	

Travel:

Have you any difficulty with driving due to your illness or injury? No ☐ Yes ☐ If yes, describe:	
Have you any difficulty using public transport without assistance? No ☐ Yes ☐ If yes, describe:	

Communication:

Have you any difficulty with your hearing? No ☐ Yes ☐ If yes, describe:	
Do you wear hearing aids? No ☐ Yes ☐	
Have you any difficulty with your speech? No ☐ Yes ☐ If yes, describe:	

Vision:

Have you any difficulty with your vision? No ☐ Yes ☐ If yes, describe:	
Are you registered with the National Council for the Blind (NCBI)? No ☐ Yes ☐	

Please use the space below to provide any additional information:

Part 10 Declaration

I declare that the information given by me in all parts of 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.

Your signature, **not** block letters

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

Signature of witness, **not** block letters

Date: D D M M 2 0 Y Y 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.

Please note that the department's doctor may be asked to provide us with an opinion to say if 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 if you satisfy the medical eligibility for Disability Allowance. It is therefore important that you fully complete all parts of this form and provide full details of your medical condition and how it affects your everyday life and ability to work. This is to ensure that we consider all relevant matters 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 11b, you should request them to enclose copies of any recent reports from specialists such as consultants, psychiatrists, psychologists, physiotherapists and counsellors. Your doctor should also enclose any test results or other information that they think is relevant. This will ensure we have a full picture of your medical condition when we make a decision on your claim.

Appoint an agent form

If you are unable to manage your own financial affairs, an agent may be appointed to collect your payment and act on your behalf. This type of agent is appointed to ensure that your payment is used for your benefit and that any changes in your circumstances that may affect your payment are reported to the Department. For example, changes in your household composition or income. A formal application must be made on your behalf and this must be certified by your doctor. You may get an authority to appoint an agent application form (AGENT) from your local Intreo Centre or **www.gov.ie/appointagent**

Part 11a 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 11b 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.

Your signature, **not** block letters

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

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

Signature of witness, **not** block letters

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

Data Protection Statement

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Part 11b Medical report by your doctor

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess their eligibility or continued eligibility for Disability Allowance, please complete the medical report on the next page. 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 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.

1. Patient details **Note:** Please use BLOCK CAPITALS

Surname:

First name:

Address:

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

PPS Number:

Mobile phone Number:

Note: The patient may be contacted by text message in relation to a medical assesment

Occupation:

2a. Your patient since: D D M M Y Y Y Y

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

3. Diagnosis

4. ICD10 Codes:

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 and obstetrical history

Attach relevant reports, test results and referrals.

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

Attach any relevant reports and results of investigations.

Additional Information:

Ability and 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 and behaviour	☐	☐	☐	☐	☐
Learning and intelligence	☐	☐	☐	☐	☐
Consciousness and seizures	☐	☐	☐	☐	☐
Balance and co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual Dexterity	☐	☐	☐	☐	☐
Lifting and carrying	☐	☐	☐	☐	☐
Bending, kneeling and squatting	☐	☐	☐	☐	☐
Sitting and rising	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs and ladders	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

This section is only relevant to Companion Free Travel Pass applications

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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 2 0 Y Y Y Y

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