Social Welfare Services
DA 1

Data Classification Confidential

Application form for
Disability Allowance

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

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

If you do not have a spouse, civil partner or cohabitant, fill in **Parts 1, 2, 3, 4, 5,** and **6**. You should sign **Part 10** confirming that you allow your doctor to give us the medical information needed to decide if you qualify for Disability Allowance. When form is completed, read **Part 9** and sign declaration in **Part 1**.

If you have a spouse, civil partner or cohabitant:

If you have a spouse, civil partner or cohabitant, fill in **Part 1, 2, 3, 4, 5, 6, 7** and **8**. You should sign **Part 10** confirming that you allow your doctor to give us the medical information needed to decide if you qualify for Disability Allowance. When form is completed, read **Part 9** and sign declaration in **Part 1**.

Doctor:

Please fill in the medical report at **Part 10**. 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 Social Welfare Office or Citizens Information Centre.

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.:** 1234567T

2. **Title:** (insert an 'X' or specify) Mr. [ ] Mrs. [X] 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 (DD MM YYYY)

Contact Details

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

10. **Your telephone number:**
0861234567 MOBILE
017043000 LANDLINE

11. **Your email address:** MMURPHY@WELFARE.IE

SAMPLE

Application form for
Disability Allowance

Social Welfare Services
DA 1

Data Classification
Confidential

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 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 means or circumstances change.

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

Date: D D M M 2 0 Y Y

Signature (**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.

11111

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 includes savings, property (other than your own home), foreign pensions etc. Please include written evidence such as statements and payslips with your application.

If you are married, in a civil partnership or cohabiting with someone , 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.

Please complete fully the remainder of this section. Do not leave any question blank. If no income, please enter 0 in each box.

15. Are you currently in employment?

☐ Yes ☐ No

If 'Yes', please state:

Employer's name:

Employer's address:

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

Gross weekly earnings: € _ , _ _ _ . _ _ a week

Please attach your most recent payslip

16(a). Are you self-employed? ☐ Yes ☐ No

16(b). If you are or have been self-employed, please state:

Type of work you do:

Dates of self-employment: From: DD MM YYYY
To: DD MM YYYY

Net yearly earnings: € , . a year

This is the money you have made from self-employment after deducting operating expenses.

17(a). Do you own or work a farm of land?

Yes No

If 'Yes', please state:

Size of farm or land: acres

Net yearly income: € , .

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

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

Net yearly income: € , .

18(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:
Community employment:	Yes	No	DD MM YYYY
Rural Social Scheme:	Yes	No	DD MM YYYY
Area-Based Initiative:	Yes	No	DD MM YYYY
Back to Work Scheme:	Yes	No	DD MM YYYY
Vocational Training Opportunities Scheme:	Yes	No	DD MM YYYY
Back to Education Allowance:	Yes	No	DD MM YYYY
Community Services Programme:	Yes	No	DD MM YYYY
FAS course or schemes:	Yes	No	DD MM YYYY
Other course (such as a rehabilitative course):	Yes	No	DD MM YYYY
School or college:	Yes	No	DD MM YYYY

33333

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

€ ☐,☐☐☐.☐☐ a week

19. If you are receiving maintenance, please state:

Amount: € ☐,☐☐☐.☐☐ a week

20. If you are receiving maintenance, please state the amount of mortgage or rent you are paying:

Amount: € ☐,☐☐☐.☐☐ a week

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

21. 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.

22. Are you getting any other pension or allowance?

☐ 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.

23. Do you have savings or accounts in a bank, post office, building society, credit union or any other financial institution?

☐ Yes ☐ No

If 'Yes', please state:

Financial Institution 1

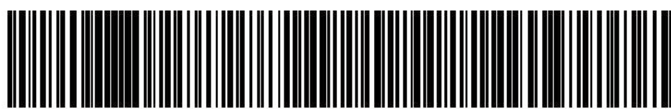
Name of financial institution:

Sort code:

Account number:

Current balance: € ☐☐☐,☐☐☐.☐☐

Name of account holder:



Financial Institution 2

Name of financial institution:

Sort code:

Account number:

Current balance: € ___ , ___ . __

Name of account holder:

Financial Institution 3

Name of financial institution:

Sort code:

Account number:

Current balance: € ___ , ___ . __

Name of account holder:

Financial Institution 4

Name of financial institution:

Sort code:

Account number:

Current balance: € ___ , ___ . __

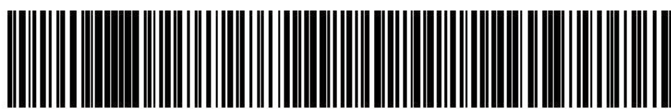
Name of account holder:

Please attach a statement for **each** account, showing balance for the last **six** months.

24. Have you made or do you intend to make a claim for compensation?

☐ Yes ☐ No

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



25. Do you own stocks, shares or investments?

☐ Yes ☐ No

If 'Yes', please state:

Name of company:

Number of shares held: ___ , ___

Their value: € ___ , ___ . __

Please attach a statement to show details.

26. Do you have 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 17.

Current market value: € _ , ___ , ___ . __

Please attach a statement from Auctioneer/Valuer confirming current market value.

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.

27. Do you have any other income?

☐ Yes ☐ No

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

28. 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:

29. If you have moved from your home, please give details in the space provided if your home is rented, occupied by other people or otherwise being used:

30. If you have recently sold your home to buy another, please outline the circumstances in the space provided and attach a copy of the deed of transfer:

Part 3 Habitual Residence Condition

31. What country were you born in?

32. What is your nationality?

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

D D M M Y Y Y Y

34. 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 ☐

88888

Part 4 Your payment details

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

Post Office

Post Office 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

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

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

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:

Name(s) of account holder(s):

Name 1:

Name 2 (if any):

Please attach a recent bank statement.

99999

Part 5 Details of your qualified child(ren)

35. How many children do you wish to claim for?

☐☐ under age 18

☐☐ age 18 - 22 in full-time education

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

Please state child's:

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

Child 5

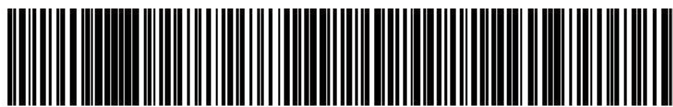
Surname:

First name(s):

PPS No.:

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

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



AAAAA

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**.

36. 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 3 allowances:

- **Electricity or Gas Allowance**
- **Telephone Allowance and**
- **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.

37. 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.

38. The following people live with me:

Person 1

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed

If so, state weekly amount: € , .

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: € , .

BBBBB

Other payments

Person 2

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed

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

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: € ☐, ☐☐☐. ☐☐

Person 3

Surname:

First name(s):

PPS No.:

Are they: ☐ Employed ☐ Self-employed

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

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: € ☐, ☐☐☐. ☐☐

Other payments

Person 4

Surname: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First name(s): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PPS No.: ☐☐☐☐☐☐☐☐☐

Are they: ☐ Employed ☐ Self-employed

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

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: € ☐,☐☐☐.☐☐

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

39. Their PPS No.: ☐☐☐☐☐☐☐☐☐

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

41. Their surname:

42. Their first name(s):

43. Their birth surname:

44. Their mother's birth surname:

45. Their date of birth: D D / M M / Y Y Y Y

46. 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.

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

☐ Yes ☐ No

48. Are they employed at present?

☐ Yes ☐ No

If 'Yes', please state:

Employer's name:

Employer's address:

Gross weekly earnings: € ☐, ☐☐☐. ☐☐ a week

Please attach their most recent payslip

Number of days worked: ☐ a week

49. Are they are self-employed at present?

☐ Yes ☐ No

If 'Yes', please state:

Type of work they do:

Date they started self-employment: 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.

EEEEE

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

50(a). Do they own or work a farm of land?

☐ Yes ☐ No

If 'Yes', please state:

Size of farm or land: ☐☐☐ acres

Net yearly income: € ☐☐,☐☐☐.☐☐

'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: € ☐☐,☐☐☐.☐☐

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 they insert an X in the Yes box.

			Date you started:
Community employment:	☐ Yes	☐ No	DD MM YYYY
Rural Social Scheme:	☐ Yes	☐ No	DD MM YYYY
Area-Based Initiative:	☐ Yes	☐ No	DD MM YYYY
Back to Work Scheme:	☐ Yes	☐ No	DD MM YYYY
Vocational Training Opportunities Scheme:	☐ Yes	☐ No	DD MM YYYY
Back to Education Allowance:	☐ Yes	☐ No	DD MM YYYY
Community Services Programme:	☐ Yes	☐ No	DD MM YYYY
FAS course or schemes:	☐ Yes	☐ No	DD MM YYYY
Other course (such as a rehabilitative course):	☐ Yes	☐ No	DD MM YYYY
School or college:	☐ Yes	☐ No	DD MM YYYY

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

€ ☐,☐☐☐.☐☐ a week

52. If they are receiving maintenance, please state:

Amount: € ☐,☐☐☐.☐☐ a week

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

53. 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.

54. Are they getting any other pension or allowance?

☐ 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.

55. Have they savings or accounts in a bank, post office, building society, credit union or any other financial institution?

☐ Yes ☐ No

If 'Yes', please state:

Financial Institution 1

Name of financial institution:

Sort code:

Account number:

Current balance: € ___ , ___ . __

Name of account holder:

Financial Institution 2

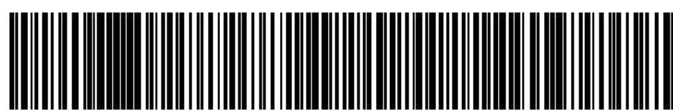
Name of financial institution:

Sort code:

Account number:

Current balance: € ___ , ___ . __

Name of account holder:



GGGGG

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

Financial Institution 3

Name of financial institution:

Sort code:

Account number:

Current balance: € ___,___.__

Name of account holder:

Financial Institution 4

Name of financial institution:

Sort code:

Account number:

Current balance: € ___,___.__

Name of account holder:

Please attach a statement for **each** account, showing balance for the last **six** months.

56. Do they own stocks, shares or investments?

☐ Yes ☐ No

If 'Yes', please state:

Name of company:

Number of shares held: ___,___

Their value: € ___,___.__

Please attach a statement to show details.

57. Have they 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: € _,___,___.__

Please attach a statement from Auctioneer/Valuer confirming current market value.

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.

HHHHH

58. Do they have any other income?

☐ Yes ☐ No

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

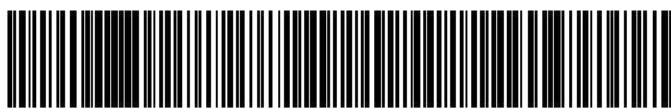
59. Did they sell or transfer property or business in the last three years?

☐ Yes ☐ No

If 'Yes', please give details in the space provided and attach a copy of the deed of transfer:

60. If they have moved from their home, please give details in the space provided if their home is rented, occupied by other people or otherwise being used:

61. If they have recently sold their home to buy another, please outline the circumstances in the space provided and attach a copy of the deed of transfer.



Part 9 Checklist

Have you enclosed the following?

- **Your 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 financial institutions for the last 6 months**
  (if you or your spouse, civil partner or cohabitant have money, investments or shares 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 have 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 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.

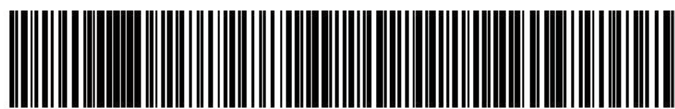
Remember to send in all the certificates and documents with this application, or say that you will send them later.

Please remember your claim cannot be processed without the medical part being completed.

Please remember to sign the Declaration in Part 1.

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

The medical report is quite detailed, so your doctor may not be able to complete it immediately. They may ask you to return to collect the fully completed form. To keep your details confidential the doctor may tear away the medical report portion of the form and return it to you in a sealed envelope. When you are returning the application form to us, make sure that you include this sealed envelope containing the medical report with all other documents and certificates you must supply. (See checklist above.)



JJJJJ

Checklist

Send this completed application form to:

Disability Allowance Section
Social Welfare Services
Government Buildings
Ballinalee Road
Longford

LoCall: 1890 92 77 70 (from the Republic of Ireland only)
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.

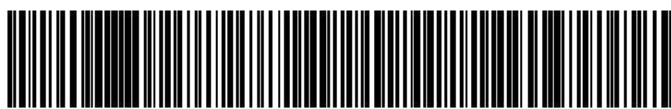
Note

The rates charged for using 1890 (LoCall) numbers may vary among different service providers.

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.



Medical Report for Disability Allowance

Part 10 Permission to release medical information

Please sign the authorisation below, which will allow your doctor to give this Department the necessary medical information for your application for Disability Allowance. **Your doctor should then complete Part 11 of this form.**

The medical information provided will be reviewed by one of our medical assessors and will be treated in strictest confidence. Although a confidential document, medical and non-medical people will need to deal with this report.

Permission

I permit my doctor to provide you, the Department of Social Protection, with medical information that may be required for my application for Disability Allowance.

Signature (**not** block letters)

Date: D D M M 2 0 Y Y

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

Witness Signature (**not** block letters)

Date: D D M M 2 0 Y Y

Part 11 Medical report by your doctor

Dear Doctor,
To enable us, on behalf of your patient, to accurately assess their eligibility/continued eligibility for Disability Allowance, please complete the medical report overleaf. The medical information provided will be reviewed by our medical assessors and will be handled in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

You can get a special fee for fully completing and returning this report. To ensure payment please enter your 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 11 Medical report by your doctor

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

Occupation:

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

7. Please give:

Medical history

Surgical/Obstetrical history

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:

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:

This section is only relevant to Companion Free Travel Pass applications

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

☐ Yes ☐ No

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

☐ Yes ☐ No

This section is only relevant to Illness Benefit Exemptions

14(a). Is the customer suitable for work/training for rehabilitative and occupational therapy purposes?

☐ Yes ☐ No

14(b). Are there any health and safety issues with regard to the employment/training described?

☐ Yes ☐ No

If the answer to question (a) is No or to question (b) is Yes, please provide details:

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: DD MM 20YY

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: DD MM YYYY

(iv) DNRA: ☐

(v) Not eligible for Disability Allowance: ☐

Give reasons:

Signed ______________________________ **Medical Assessor**

Date: DD MM 20YY

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.

85K 03-11

Edition: May 2010