

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:

M	U	R	P	H	Y														
---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4. First names:

M	A	U	R	E	E	N													
M	A	R	Y																

5. Birth surname:

M	C	D	E	R	M	O	T	T											
---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--

6. Your date of birth:

2	8		0	2		1	9	7	0
D	D		M	M		Y	Y	Y	Y

7. Your address:

1		N	E	W		S	T	R	E	E	T								
O	L	D		T	O	W	N												
D	O	N	E	G	A	L		T	O	W	N								
County		D	O	N	E	G	A	L											
Eircode		C	1	5	A	9	6	V											

8. Your mobile phone number:

0	8	8	1	2	3	4	5	6	7										
---	---	---	---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--

9. Your email address:

M	M	U	R	P	H	Y	@	W	E	L	F	A	R	E	.	I	E		

10. Are you?

<input type="checkbox"/> Single	<input type="checkbox"/> Cohabiting
<input checked="" type="checkbox"/> Married	<input type="checkbox"/> In a Civil Partnership
<input type="checkbox"/> Separated	<input type="checkbox"/> A surviving Civil Partner
<input type="checkbox"/> Divorced	<input type="checkbox"/> A former Civil Partner
<input type="checkbox"/> Widowed	(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?

0	1		0	1		1	9	9	9
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

SAMPLE

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

		You		Partner	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?

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:

Your signature, **not** block letters

Date:

D D M M Y Y Y Y

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

Signature of agent, **not** block letters

Date:

D D M M Y Y Y Y

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.

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.

Medical Report for Disability Allowance

Social Welfare Services

Med Rpt DA1

Data Classification R



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 treatment 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:

<p>Name:</p> <p>Address:</p>

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 <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	
Can you climb stairs without assistance? No <input type="checkbox"/> Yes <input type="checkbox"/> If no, specify:	
Does your disability, medical condition, illness or injury affect sitting or standing? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	
Have you any difficulty with balance or co-ordination? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	
Have you any difficulty with the use of your hands? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	
Have you difficulty with lifting or carrying? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	

Mental Health:

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

Activities of daily living (ADL):

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

Showering No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	
Dressing No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	
Toileting No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	
Housework or Cooking No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	
Shopping No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	
Care of Family No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, specify:	

Travel:

Have you any difficulty with driving due to your illness or injury? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	
Have you any difficulty using public transport without assistance? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	

Communication:

Have you any difficulty with your hearing? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	
Do you wear hearing aids? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Have you any difficulty with your speech? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	

Vision:

Have you any difficulty with your vision? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, describe:	
Are you registered with the National Council for the Blind (NCBI)? No <input type="checkbox"/> Yes <input type="checkbox"/>	

Please use the space below to provide any additional information:

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 Y Y Y Y

Signature of witness, **not** block letters

Date:
D D M M 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

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 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 Y Y Y Y

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5. Date condition started:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	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 →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning and intelligence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consciousness and seizures →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance and co-ordination →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Manual Dexterity →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting and carrying →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, kneeling and squatting →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting and rising →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing stairs and ladders →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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00K-04-22

Edition: April 2022

Page 22

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