

Application form for Homemaker's Scheme



How to complete application form for Homemaker's Scheme.

- 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 or partner fill in **Part 1** and **3**. The person or people you are or were caring for should sign **Part 4** confirming that they require or required care. You should then get the doctor to complete the medical report, **Part 6**. When the form is completed, read **Part 5** and sign and sign the declaration in **Part 1**.

If you have a spouse or partner fill in **Parts 1,2** and **3** as they apply to you. The person or people you are or were caring for should sign **Part 4** confirming that they require or required care. You should then get the doctor to complete the medical report **Part 6**. When the form is completed, read **Part 5** and sign the declaration in **Part 1**.

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 in first page of 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:

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

4. First name(s):

M	A	U	R	E	E	N											
---	---	---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--

5. Your first name as it appears on your birth certificate:

M	A	R	Y														
---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--

6. Birth surname:

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

7. Your mother's birth surname:

K	E	L	L	Y													
---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--

8. Your date of birth:

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

9. Your address:

1		N	E	W		S	T	R	E	E	T						
O	L	D			T	O	W	N									
C	O		D	O	N	E	G	A	L								

10. Your telephone number:

0	8	6	1	2	3	4	5	6	7				
MOBILE													
0	1	7	0	4	3	0	0	0					
LANDLINE													

11. Your email address:

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

SAMPLE

Application form for Homemaker's Scheme

Social Welfare Services

HM 1



Part 1

Your own details

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.

Signature (not block letters)

Date:
D D M M

Y Y Y Y

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.



Part 1 continued

Your own details

12. What country were you born in?

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

13. What is your old Social Insurance number?

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

14. Are you?

<input type="checkbox"/> Single	<input type="checkbox"/> Widowed	<input type="checkbox"/> Remarried	<input type="checkbox"/> Divorced
<input type="checkbox"/> Married	<input type="checkbox"/> Cohabiting	<input type="checkbox"/> Separated	

15. When did you get married?

D	D	M	M	Y	Y	Y	Y

16. Are you getting Child Benefit from this Department for the child(ren) in your care?

☐ Yes ☐ No

Note: If you are in receipt of Child Benefit, you do not need to complete this form.

If 'No', from what country is payment being paid?

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

If 'Yes', who is getting the Child Benefit payments?

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

How is this person related to you?

☐ Spouse (your husband or wife)

☐ Partner (a man or woman you live with but are not married to)

☐ Guardian of child(ren)

☐ Grandparent of child(ren)

☐ Other, state relationship here, for example, aunt, sister

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

17. Are you getting Carer's Allowance or Carer's Benefit?

☐ Yes ☐ No

If 'No', have you ever applied for Carer's Allowance or Carer's Benefit?

☐ Yes ☐ No

If 'Yes', what year did they apply?

--	--	--	--

18. Have you ever applied for Respite Care Grant?

☐ Yes ☐ No

If 'Yes', what year did you apply?

--	--	--	--

19. Are you getting Jobseeker's Allowance or Jobseeker's Benefit?

☐ Yes ☐ No



20. Are you signing for:Jobseeker's Benefit
Credits?☐ Yes☐ NoPre-Retirement Allowance
Credits?☐ Yes☐ No**21. Are you employed at present?**☐ Yes☐ No**If 'Yes', please state:**

Who you worked for:

What is your gross
weekly pay?€ , . a week

Please attach your most recent payslip or P60

'Gross pay' is your pay **before** any deductions, such as tax, PRSI or union dues.**If 'No', please state:**

When you last worked:

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
D D	M M	Y Y Y Y

Please attach your P45

Who you last worked for:

22. Are you self-employed at present?☐ Yes☐ No(You are 'self-employed' if
you work for yourself).**If 'Yes', what is your
gross yearly income?**€ , . a week

Please attach a statement from your accountant.

'Gross pay' is your pay **before** any deductions, such as tax, PRSI or union dues.**If 'No', when did you last
work as self-employed?**

<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
D D	M M	Y Y Y Y

Please attach a statement from your accountant to confirm this date.



23. If you are employed or self-employed, do you intend to give up this work to provide full-time care and attention for the person or people named in Part 3?

☐ Yes

☐ No

If 'Yes', when will you give up this work?

D D

M M

Y Y Y Y

Please attach a letter from your employer or a statement from your accountant if you are self-employed to confirm this date.

24. Are you attending an educational or training course outside the home?

☐ Yes

☐ No

If 'Yes', how many hours do they attend?

a week

What type of course is it?

☐ Vocational Training Opportunities Scheme (VTOS)

☐ FÁS Training

Other:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Please specify

25. Are you getting an occupational or private pension?

If 'Yes', please state:

☐ Yes

☐ No

Who pays the pension?

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Amount you get:

€

, . a week

Please attach the most recent payslip or letter from company paying you to confirm this amount.



Part 2

Your spouses or partner's details

26. Their PPS No.:

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

27. Title: (insert an 'X' or specify)

Mr. ☐

Mrs. ☐

Ms. ☐

Other

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

28. Their surname:

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

29. Their first name(s):

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

30. Their birth surname:

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

31. Their mother's birth surname:

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

32. Their date of birth:

--	--

D D

--	--

M M

--	--	--	--

Y Y Y Y

33. What is their old Social Insurance Number, if any?

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

This number was used prior to 1979 - if they have no number write 'none'

34. Is your spouse or partner employed or self-employed?

☐ Yes

☐ No

Part 3

Details of person or people who need care

35. Please give details of all members of your household who need or needed full-time care and attention as follows:

List people here for whom you give or have given full-time care and attention (including adults or children over age 12 who are incapacitated).

Please state:

Person 1

36. Their PPS No.:

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

37. Their surname:

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

38. Their first name(s):

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

39. Their birth surname:

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

40. Their mother's birth surname:

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

41. Their date of birth:

--	--

D D

--	--

M M

--	--	--	--

Y Y Y Y

42. Their old Social Insurance No., if any:

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

43. Country they were born in:

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

44. Do they live with you?

☐ Yes

☐ No

45. Type of payment they are getting, if any:

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



46. Name of country that pays them:

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

47. Are you getting a Domiciliary Care Allowance for this person?

☐ Yes ☐ No

If 'Yes', please attach confirmation of Domiciliary Care Allowance

48. What date did caring start?

D	D	M	M	Y	Y	Y	Y

49. What date did caring cease?

D	D	M	M	Y	Y	Y	Y

If care is ongoing please tick here:

☐

Please attach their birth certificates if born outside the Republic of Ireland. (We do not accept photocopies).

50. Is anyone else getting Carer's Allowance or Carer's Benefit for them?

☐ Yes ☐ No

51. Are the person(s) cared for working outside the home?

☐ Yes ☐ No

If 'Yes', please state:

Employers name:

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

Address:

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

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

Type of work:

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

Number of hours:

--	--

 a week

52. Are the person(s) cared for attending a training or educational training course outside the home?

☐ Yes ☐ No

If 'Yes', how many hours do they attend?

--	--

 a week

What type of course is it?

☐ Vocational Training Opportunities Scheme (VTOS)

☐ FÁS Training

Other:

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

Please specify

53. Has this person had any in-patient stays in a Hospital or a Convalescent home or similar type of institution during the period being claimed?

☐ Yes ☐ No

If possible the person or people being cared for should sign the declaration at Part 4. A doctor must supply Medical Certificate details in Part 5 for period(s) of care.



Please state:

Person 2

54. Their PPS No.:

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

55. Their surname:

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

56. Their first name(s):

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

57. Their birth surname:

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

58. Their mother's birth surname:

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

59. Their date of birth:

D	D	M	M	Y	Y	Y	Y		

60. Their old Social Insurance No., if any:

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

61. Country they were born in:

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

62. Do they live with you?

☐ Yes ☐ No

63. Type of payment they are getting, if any:

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

64. Name of country that pays them:

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

65. Are you getting a Domiciliary Care Allowance for this person?

☐ Yes ☐ No

If 'Yes', please attach confirmation of Domiciliary Care Allowance

66. What date did caring start?

D	D	M	M	Y	Y	Y	Y		

67. What date did caring cease?

D	D	M	M	Y	Y	Y	Y		

If care is ongoing please tick here:

☐

Please attach their birth certificates if born outside the Republic of Ireland. (We do not accept photocopies).

68. Is anyone else getting Carer's Allowance or Carer's Benefit for them?

☐ Yes ☐ No

69. Are the person(s) cared for working outside the home?

☐ Yes ☐ No


If 'Yes', please state:

Employers name:

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

Address:

Type of work:

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

Number of hours worked:

--	--

 a week

70.Are the person(s) cared for attending a training or educational training course outside the home?

☐ Yes ☐ No

If 'Yes', how many hours do they attend?

--	--

 a week

What type of course is it? ☐ Vocational Training Opportunities Scheme (VTOS) ☐ FÁS Training

Other:

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

Please specify

71.Has this person had any in-patient stays in a Hospital or a Convalescent home or similar type of institution during the period being claimed?

☐ Yes ☐ No

If possible the person or people being cared for should sign the declaration at Part 4. A doctor must supply Medical Certificate details in Part 5 for period(s) of care.



Part 4

Declaration by person receiving full-time care and attention

The person or people who are getting or who have received full-time care and attention as listed in Part 3 must fill in this part but only if they are aged 12 or over.

Note: Children under age 12 do not have to complete this part.

I declare that I need or needed full-time care and attention for the period stated in Part 3 and that the person named in Part 1 is providing full-time care and attention for me. I will tell the Department of Social Protection if this changes.

Person 1

Signature (not block letters)

Date:

D	D

M	M

2	0		
Y	Y	Y	Y

If you cannot sign, make a mark and have it witnessed. The witness should sign below.

Signature (not block letters)

Date:

D	D

M	M

2	0		
Y	Y	Y	Y

Person 2

Signature (not block letters)

Date:

D	D

M	M

2	0		
Y	Y	Y	Y

If you cannot sign, make a mark and have it witnessed. The witness should sign below.

Signature (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.



Have you enclosed the following?

- **Your birth certificate** (if born outside the Republic of Ireland)
- **Birth certificates for all people you were or are providing with full-time care** (if born outside the Republic of Ireland)
- **Letter from your employer, if you intend to leave your job to provide full-time care and attention, to confirm the date you will leave work**
- **Confirmation of Domiciliary Care Allowance** (if relevant)
- **A recent payslip or P60 if you are working**
- **A P45 if you have ceased working**
- **A statement from your accountant if you are self-employed or if you have ceased employment**

Original certificates only.

If your form is not fully complete or the documents required are not enclosed there will be a delay in deciding your claim Homemaker's Scheme.

Please remember to sign the declaration in Part 1.

Send the completed application form and other documents to:

Homemaker's Section

Department of Social Protection
Inner Relief Road
Ardarvan
Buncrana
Co Donegal

LoCall: 1890 690 690 (from the Republic of Ireland only)

Telephone: +353 1 4715898 (from Northern Ireland or overseas)

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.



A Doctor, for people who are medically, mentally or physically incapacitated, must complete this part.

Please note you must complete (a) and (b) below.

Fill in the details for all incapacitated people as listed in Part 3 of this form.

Person 1

I certify that:

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

is suffering from:

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

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

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

Did or does the above named person require:

a) full-time supervision in order to avoid danger to themselves?

and ☐ Yes ☐ No

a) full-time supervision and frequent assistance throughout the day in connection with his or her normal personal needs?

☐ Yes ☐ No

Please state duration of their incapacity:

From:

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

D D M M Y Y Y Y

To:

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

D D M M Y Y Y Y

Person 2

I certify that:

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

is suffering from:

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

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

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

Did or does the above named person require:

a) full-time supervision in order to avoid danger to themselves?

and ☐ Yes ☐ No

a) full-time supervision and frequent assistance throughout the day in connection with his or her normal personal needs?

☐ Yes ☐ No

Please state duration of their incapacity:

From:

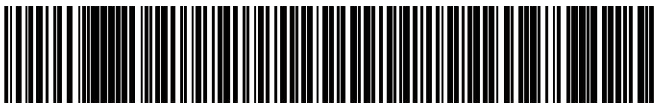
--	--	--	--	--	--	--	--	--	--

D D M M Y Y Y Y

To:

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

D D M M Y Y Y Y



Doctor's name:

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

DSFA panel number:

--	--	--	--	--

IMC number:

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

Address:

--

Doctor's official stamp

--

Doctor's Signature (not block letters)

Date:

<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td>2</td><td>0</td><td></td><td></td></tr></table>	2	0		
2	0									
D D	M M	Y Y Y Y								

Please attach any relevant reports/results of investigations.

Additional Information:

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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.

