



Application form for Domiciliary Care Allowance

What is Domiciliary Care Allowance?

Domiciliary Care Allowance (DCA) is a monthly payment for a child under 16 years of age with a severe disability. The child must require ongoing care and attention, substantially over and above what is usually needed by a child of the same age.

How does a child qualify?

To qualify for Domiciliary Care Allowance, a child must:

- be under 16 years of age.
- be resident in Ireland.
- have a severe disability that is likely to impact them for at least 12 months.
- need ongoing care and attention substantially more than what is usually required by a child of the same age.
- live with the person claiming Domiciliary Care Allowance for at least 5 days a week.

There are some exceptions. For example, if the child's parents are living apart or if the child attends residential care part-time.

The person claiming Domiciliary Care Allowance must:

- provide for the care of the child.
- be habitually resident in the State.

There are no PRSI conditions for DCA and it is not means tested. You can find out more about who can get Domiciliary Care Allowance on **www.gov.ie/DCA**

When to apply?

You should apply for Domiciliary Care Allowance as soon as you believe your child meets the medical criteria. This helps ensure your application is considered from the earliest possible date.

How to apply?

The quickest and easiest way to apply for Domiciliary Care Allowance is through **MyWelfare.ie**. All you need is a verified MyGovID account. You can get a verified MyGovID account if you have a Public Service Card, a verified mobile phone number and an email address.

Alternatively, you can print and complete the application form **DomCare1** and send it, with a completed **DCAMed1**, which is provided at the end of this form, to:

Domiciliary Care Allowance

Department of Social Protection
Government Buildings
Ballinalee Road
Longford
N39 E4E0

Note: If your child has a pervasive developmental disorder (PDD), e.g. Autism Spectrum Disorder, you may wish to have the medical professional or specialist dealing with your child complete an additional medical form **DomCare3** available on **www.gov.ie/DCA**, from your local Intreo Centre, Social Welfare Office or Citizens Information Centre.

How to fill in this form

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

Part 1

Your details

1. PPS number:

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2. Surname:

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3. First names:

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4. Date of birth:

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6. Telephone number:

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Note: If you enter your mobile number we may text you in connection with your claim.

7. Email address:

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SAMPLE



Application form for Domiciliary Care Allowance

Part 1

Your details

1. PPS number:

2. Surname:

3. First names:

4. Date of birth:

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Y

Y

Y

Y

5. Address:

County

Eircode

6. Telephone number:

Note:

If you enter your mobile number we may text you in connection with your claim.

7. Email address:

Page 1

Part 2

Details of the child you are claiming for

1. Child's PPS number:

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2. Child's surname:

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3. Child's first names:

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4. Child's date of birth:

D	D	M	M	Y	Y	Y	Y		

5. Relationship to you:

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6. Address if different from yours:

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7. Does the child you are caring for live with you 7 days per week?

☐ Yes☐ No

If **no**, please answer Q8,Q9,Q10 and Q11 as applicable:

8. On average, how many days per week does the child live with you?

 days per week

9. Where does the child you are caring for live on the days they are not with you?

☐ With another parent or guardian ☐ In a special school, care centre or other care setting

10. If they are living with another parent or guardian please provide their:

Surname:

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First names:

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11. If they are living in a special school, care centre or other care setting please provide details below:

Name of school or care centre:

Address:

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Part 2 continued

Details of the child you are claiming for

12. Does the child stay overnight in a special school, care centre or other care setting at any time during the year? ☐ Yes ☐ No

13. On average, how many nights per week does the child stay overnight in a school, care centre or other care setting? nights per week

14. If they stay overnight a special school, care centre or other care setting please provide details below:

Name of school or care centre:

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Part 3

Your payment details

You can get your payment at a post office of your choice or direct to your current, deposit or savings account in a financial institution. An account must be in your name or jointly held by you.

Please complete **one** option below.

Financial Institution

You will find the following details printed on statements from your financial institution.

Name of financial institution:

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International Bank Account Number (IBAN):

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Bank Identifier Code BIC:

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Names of account holders:

Name 1:

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Name 2, if any:

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Post Office

Post office name:

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Address:

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This section allows you to tell us about the extra care your child needs compared with a child of the same age without the same disability. We understand that it might be hard to answer some of these questions, but please give us as much information as you can in support of your application.

If you need more room, feel free to use another sheet of paper. It will help us if you write the heading and number at the top of the page, for example **4.1.1 Mobility and co-ordination**. Don't forget to attach the page to this form and put your name and Personal Public Service (PPS) Number on the top of each page.

4.1.1 Mobility and co-ordination

Does the child you care for often need help moving to and from any of these items? Please tick all that apply:

☐ A chair or wheelchair ☐ A bed ☐ A toilet, bath or shower

☐ No, they do not often need help with this

Compared to children of the same age, does the child have difficulty walking or moving around?

☐ Yes ☐ No

For example: they may experience chronic pain or require a mobility aid such as a walking frame.

If **yes**, please tell us about their difficulties walking or moving around, including how often they occur, how they impact daily life and the care you provide to help:

Can the child you care for:

Come down stairs without help?

☐ Yes ☐ No ☐ Does not apply

Do they have mobility or co-ordination difficulties that affect their ability to write or draw?

☐ Yes ☐ No ☐ Does not apply

Do they have balance and co-ordination difficulties that affect their ability to hop, skip or jump?

☐ Yes ☐ No ☐ Does not apply

Do they often lose balance, trip or fall?

☐ Yes ☐ No ☐ Does not apply

Are there other details we should know about the child's mobility, balance or co-ordination and their related care needs?

☐ Yes☐ No

For example, how often difficulties occur or how they impact daily life

If **yes**, please provide details below:

4.1.2 Feeding and Diet

Compared to children of the same age, do any of the below apply to their needs:

Needs extra help or assistance to eat or drink?

☐ Yes☐ No☐ Does not apply

For example: need supervision while eating or require the use of a feeding tube.

Eats only certain foods or follows a special diet?

☐ Yes☐ No☐ Does not apply

Do they have any food allergies?

☐ Yes☐ No☐ Does not apply

Do you often have to monitor their food intake?

☐ Yes☐ No☐ Does not apply

Do they often have difficulty using any of the following utensils:

Please tick all that apply:

☐ A spoon to feed themselves☐ A knife and fork to cut food☐ No, they do not often have these difficulties

If you have answered **yes** to any of the above questions, please give details of how they impact daily life and any care you provide to help:

Are there other details we should know about the child's diet and related care needs?

If **yes**, please provide details below including how they impact daily life, any specialist equipment needed and any care you provide to help:

4.1.3 Sleeping

Compared to children of the same age, does the child you care for often wake up during the night?

☐ Yes☐ No

If **yes**, please answer the following questions:

On average, how many times per night do they wake up?

☐ 1 time per night☐ 2-3 times per night☐ 3-4 times per night☐ More than 5 times per night

How long do they usually take to settle when they wake up during the night?

☐ Settles within 15 minutes☐ Settles within 1 hour☐ Takes longer than 1 hour to settle

Within a typical month, how often do they experience these sleeping issues?

☐ 1-3 times a month☐ 1-3 times per week☐ Most nights

Please give details of extra help they need going to sleep or at night:

Are there other details we should know about their sleeping and related care needs? For example, regular bed wetting or sleepwalking?

☐ Yes

☐ No

If **yes**, please include how often these difficulties occur and how they impact daily life:

4.1.4 Personal Care

Can the child you care for use the toilet by themselves?

☐ Yes

☐ No

☐ Does not apply

Do they often have problems with wetting and soiling?

☐ Yes

☐ No

☐ Does not apply

Do they often need to wear nappies, pull-ups or incontinence pads?

☐ Yes

☐ No

☐ Does not apply

Are there other details we should know about their toileting and related care needs?

If **yes**, please include how often these difficulties occur and how they impact daily life:

Compared to children of the same age, does the child often have difficulty washing themselves without help? Depending on the child's age, this might include washing their teeth, hands, face or body.

☐ Yes

☐ No

☐ Does not apply

If **yes**, please give details of the help and support the child you are caring for needs to wash, including:

- the difficulties they experience washing themselves
- the care you provide to help and support them
- how often they require this care
- how this impacts daily life

Compared to children of the same age, does the child you care for often have difficulty dressing themselves? Depending on the child's age, this might include managing buttons and zips.

☐ Yes☐ No☐ Does not apply

If **yes**, please give details of the help and support they need to dress, including:

- the difficulties they experience dressing themselves
- the care you provide to help and support them
- how often they require this care
- how this impacts daily life

Are there other details we should know about the child's personal care needs and the help they require?

If **yes**, please include how often these difficulties occur and how they impact daily life:

4.1.5. Sensory

Does the child you care for have hearing or vision difficulties?

☐ Yes☐ No

If **yes**, please give details below, including how they impact daily life, the care you provide to help and any specialist equipment or assistive technologies used:

Do they experience sensory processing difficulties? This may include over-responding or under-responding to sensory information, such as light, sound, taste, smell and touch.

☐ Yes☐ No

If **yes**, please answer the following questions:

Do these sensory difficulties often limit places the child can go?

☐ Yes☐ No

Do they find it difficult to function when they are experiencing sensory processing difficulties?

☐ Yes☐ No

Do they need to use any equipment to help them with sensory regulation? For example, noise cancelling headphones or sensory toys.

☐ Yes☐ No

Please give details of the child's sensory processing difficulties, including:

- how often they occur
- how they impact daily life
- the care you provide to help

Is the child's clothing restricted because they cannot tolerate certain fabrics on their skin?

☐ Yes☐ No

4.1.6 Communication

Does the child you care for often experience difficulties with any of these communication skills?

Tick all that apply:

Speech and language skills ☐

Verbal or non-verbal communication ☐

Understanding and communicating with facial expressions and body language ☐

Communicating to you how they are feeling when they are not feeling well ☐

Understanding what you say to them and the words you use ☐

No, they do not often have these difficulties ☐

Are there other details we should know about their communication skills and related care needs?

If **yes**, please include how often these difficulties occur and how they impact daily life:

4.1.7 Social Skills

Compared to children of the same age, does the child you care for often experience difficulties with any of the following? Tick all that apply:

Adapting to changes in their routine ☐

Making decisions ☐

Problem solving ☐

Looking after their belongings ☐

Being over fixated on certain things ☐

No, they do not often have these difficulties ☐

Compared to children of the same age, do they often experience difficulties with any of the following? Tick all that apply:

Being shy or withdrawn around people they are familiar with, such as family or friends

☐ Yes ☐ No

Playing or mixing with other children

☐ Yes ☐ No

Entertaining themselves or engaging in imaginative play

☐ Yes ☐ No

Participating in events

☐ Yes ☐ No

No, they do not often have these difficulties

☐ Yes ☐ No

Compared to children of the same age, do you often need to spend more time preparing them for leaving the house?

☐ Yes ☐ No

If **yes**, please tell us about the care or support they need to prepare to leave the house. Please include details of how often you provide this care:

Are there other details we should know about the child's social skills and related care needs?

☐ Yes ☐ No

If **yes**, please include how often these difficulties occur, the care you provide to help and how they impact daily life:

4.1.8 Behaviour and Safety

Does the child you care for appear to be significantly depressed or anxious?

☐ Yes

☐ No

☐ Does not apply

Compared to children of the same age, are they often irritable, prone to outbursts or difficult to calm down?

☐ Yes

☐ No

☐ Does not apply

If **yes**, on average, how often does do they experience irritation or outbursts?

☐ Daily

☐ Weekly

☐ Monthly

☐ Every few months

On average, how long does it take them to settle after experiencing irritation or an outburst?

☐ Settles within 10-15 minutes

☐ Settles within 1 hour

☐ Takes longer than an hour to settle

Do they often experience panic or anxiety attacks?

☐ Yes

☐ No

☐ Does not apply

If **yes**, on average, how often do they experience panic or anxiety attacks?

☐ Daily.

☐ Weekly.

☐ Monthly.

☐ Every few months.

Is the child you care for aggressive to others to an unusual degree? For example, shouting, biting or kicking.

☐ Yes

☐ No

☐ Does not apply

If **yes**, on average, how often are they aggressive to others?

☐ Daily.

☐ Weekly.

☐ Monthly.

☐ Every few months.

Does the child have any behaviours that cause self-injury? For example, hair pulling, head-banging or hand biting.

☐ Yes

☐ No

☐ Does not apply

Do you need to lock household items away so they cannot access them? For example, matches, knives or cleaning fluids.

☐ Yes

☐ No

☐ Does not apply

Do they have any unusual habits or obsessions that could become dangerous? For example, fire starting, fascination with water or regularly putting foreign objects in their nose, mouth or ears?

☐ Yes

☐ No

☐ Does not apply

Compared to children of the same age, do they have poor awareness of potentially dangerous situations? For example, road or water safety.

☐ Yes

☐ No

☐ Does not apply

Do they often run away from any of these environments? Tick all that apply:

☐ Home ☐ School ☐ Social gatherings ☐ No, they do not often run away from these environments

Have any changes been made to their home, school or transport to support their needs or make it safe for them?

☐ Yes ☐ No ☐ Does not apply

For example, this may include adding stairlifts or locks on doors or windows.

If **yes**, please give details of the changes that have been made to their home, school or transport to support their needs or make it safe for them:

Do you often experience difficulties with managing the child's behaviour, emotions or safety?

☐ Yes ☐ No ☐ Does not apply

If **yes**, please give details of any difficulties you experience managing their behaviour, emotions or safety, including how often they occur and how they impact daily life:

Are there other details we should know about their behaviour, emotions or safety needs?

If **yes**, please include how these difficulties affect daily life and the care you provide to help:

4.1.9 Care needs: additional information

Additional Care needs might include:

- The use of specialist equipment
- Techniques to help with breathing
- Special feeding arrangements
- Dialysis
- Dressing wounds
- Stoma care requirements
- Special transport arrangements
- Preparation of and/or administration of medication

Does the child you care for have additional care needs that have not been already mentioned in this application?

☐ Yes☐ No

If **yes**, please give details below including:

- How often they occur
- How they impact daily life
- The care you provide to help

Do the child's care needs often prevent your family from going out together?

☐ Yes☐ No

Do their care needs impact family life or other family members on a daily basis?

☐ Yes☐ No

If **yes**, please describe how these care needs impact family life and other family members on a daily basis:

Is the child attending or waiting for an appointment with any of the following therapists, specialists or consultants?

Service	Waiting on appointment	Attending appointments	Date referred										Reports available?
Speech and Language Therapist													☐ Yes ☐ No
Occupational Therapist													☐ Yes ☐ No
Psychologist													☐ Yes ☐ No
Psychiatrist													☐ Yes ☐ No
Physiotherapist													☐ Yes ☐ No
Paediatrician													☐ Yes ☐ No
Dietician													☐ Yes ☐ No
Optician													☐ Yes ☐ No
Audiologist													☐ Yes ☐ No
Behavioural Support Therapist													☐ Yes ☐ No
Social Worker													☐ Yes ☐ No
Public Health Physician													☐ Yes ☐ No
Other therapists, specialists or consultants													☐ Yes ☐ No

Note: If they are attending any of the above services, please state how often they attend appointments and enclose copies of any available reports.

Do the care needs of the child mean that it is difficult to arrange childcare, child-minding or babysitting?

☐ Yes☐ No

If **yes**, please give details of the difficulties you have in arranging childcare, child-minding or babysitting. Please include how this impacts your work and family life.

Has the child ever been excluded from a school or childcare setting because of their care needs?

☐ Yes☐ No☐ Does not apply

If **yes**, please give details of how the child was excluded, including how often this occurs:

Does the child attend any of these school settings?

☐ Preschool☐ A special school for children with additional needs☐ A mainstream school☐ Homeschool☐ A special unit in a mainstream school☐ No, they do not attend any of these school settings

Does the child only attend for part of the school day?

☐ Yes☐ No

Has the child often had issues at school that meant you had to attend? ☐ Yes ☐ No

Have you often had to take the child home from school early due to their care needs? ☐ Yes ☐ No

Does the child have extra educational needs that require support from any of these resources? Tick all that apply:

- | | |
|--|--|
| ☐ The Access and Inclusion Model (AIM) | ☐ A Special Needs Assistant (SNA) |
| ☐ Resource hours and/or learning support | ☐ The Home Tuition Supplementary Scheme |
| ☐ A visiting teacher or specialist for visual or hearing impairment | ☐ No, they do not require support from any of these resources |

What level of Access and Inclusion Model (AIM) supports do they receive? ☐ Level

Have they ever been recommended for a Special Needs Assistant (SNA)? ☐ Yes ☐ No

Are they currently assigned to a Special Needs Assistant (SNA)? ☐ Yes ☐ No

Would you like to provide more information about extra educational needs or support requirements for the child you care for? For example, how often they need additional support, how their educational needs impact daily life or details of assistive technologies used. ☐ Yes ☐ No

If **yes**, please provide details:

If awarded, Domiciliary Care Allowance is usually paid from the month after you first apply. If you were delayed in making your claim, you may be eligible for backdating. Claims can be backdated up to 6 months.

From what date has the child required additional care?

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M	M	Y	Y	Y	Y

If there was a delay in making your claim, would you like to have it considered for backdating?

☐
 Yes

☐
 No

If **yes**, please briefly explain why you would like your claim to be considered for backdating:

Note: Claims may only be backdated up to 6 months. Lack of knowledge of the scheme is not considered good cause for backdating.

I declare that the information given by me in this application 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.

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Signature, **not** capital letters.

Date:

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If you make a false statement or withhold information, you may be prosecuted leading to a fine, a prison term or both.

Send this completed application form, and all relevant supporting documents to:

Domiciliary Care Allowance Section
Department of Social Protection
Government Buildings
Ballinalee Road
Longford
N39 E4E0

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 in hard copy.

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

Medical Report for Domiciliary Care Allowance

Part 1

Parent or Guardian's details

1. PPS number:

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2. Title, insert an **X or specify:**

	Mr		Mrs		Ms	Other					
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3. Surname:

[illegible]

4. First names:

[illegible]

5. Date of birth:

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Part 2

To be completed by the child's GP/Specialist

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess their eligibility for Domiciliary Care Allowance, please complete the medical report below. The medical information provided will be reviewed by our medical assessors and will be treated in strictest confidence.

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's details:

Surname:

[illegible]

First names:

[illegible]

Address:

[illegible][illegible]

County

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Eircode

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Date of birth:

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Y Y Y Y

2. Your patient since:

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3. Diagnoses, please use capital letters:

4. ICD10 Codes:

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5. Date condition started:

D	D	M	M	Y	Y	Y	Y								

6. How long do you expect this condition to continue?

☐	Less than 12 months.	☐	12 to 24 months.
☐	24 to 48 months.	☐	Indefinitely.

7. Please provide the patient's:

Medical History:

--

Surgical History:

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Clinical Findings:

--

Hospital admissions:

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Date of most recent admission:

D	D	M	M	Y	Y	Y	Y								

Date of discharge:

D	D	M	M	Y	Y	Y	Y								

8. Please give details if any of the following apply:

Attending a specialist:

On medication:

Other treatment:

Please attach any relevant reports.

Additional information:

Part 3

Medical Report

Indicate the degree to which the child's condition has affected their ability in each of the following areas.

Should ability in any area be inappropriate to the age of the child, please place an **X** in the N/A box.

Area	Ability level					
	Normal	Mild	Moderate	Severe	Profound	N/A
Mental health						
Behaviour						
Intelligence						
Learning						
Consciousness/Seizures						
Speech						
Communication						
Social skills						
Vision						
Hearing						
Sensory issues						
Feeding/Diet						
Sleeping						
Washing						
Dressing						
Continence						
Mobility						
Balance/Co-ordination						
Manual dexterity						
Reaching/Lifting/Carrying						
Sitting/Standing						
Climbing stairs						
Bending/Kneeling/Squatting						
Fine motor skills (age appropriate)						
Gross motor skills (age appropriate)						

9. GP or Specialist's name:

10. DSP panel number:

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11. Address:

County

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Eircode

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Doctor's signature, **not** capital letters.
Date:

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D D
M M
Y Y Y Y

Doctor's official stamp

All information given in this section is covered by the Data Protection Act and the Official Secrets Act.

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 in hard copy.

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