



Medical Report 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

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 this completed DCAMed1 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 **DomCare 3** available on www.gov.ie/DCA, from your local Intreo Centre, Social Welfare Office or Citizens Information Centre. The complete form will detail your child's conditions and any specific care needs the child might have as a result of their disability and will assist the department's Medical Assessor in forming an opinion on eligibility.

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

Parent or Guardian's details

1. PPS number:

1	2	3	4	5	6	7	T	
---	---	---	---	---	---	---	---	--

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

<input type="checkbox"/>	Mr	<input checked="" type="checkbox"/>	Mrs	<input type="checkbox"/>	Ms	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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3. Surname:

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

4. First names:

M	Á	I	R	E															
---	---	---	---	---	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

5. Date of birth:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	8	0	2	1	9	7	0
D	D	M	M	Y	Y	Y	Y

SAMPLE



Medical Report for Domiciliary Care Allowance

Part 1

Parent or Guardian's details

1. PPS number:

2. Title, insert an X or specify:

 Mr Mrs Ms Other

3. Surname:

4. First names:

5. Date of birth:

D D M M Y Y Y Y

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:

First names:

Address:

County

Eircode

Date of birth:

D D M M Y Y Y Y

2. Your patient since:

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:

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)						

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.