|  |
| --- |
| **To be eligible to apply for HSE support an applicant’s disability must:**  Be attributable to a physical and/or sensory disability **or** moderate, severe and profound intellectual disability and Autism, (or combination); **and** be permanent or likely to be permanent; **and** have occurred before the age of 65 years of age; **and** result in a restriction in participation in self-care/management, interpersonal relationships, communication, mobility, learning or applying knowledge and result in a need for ongoing significant disability supports.  As a diagnosis of a disability or the permanency of a disability may not occur for a child under 6 years of age, eligibility is based upon a significant developmental delay or risk of a significant developmental delay for applicants within this age group. |

***All sections must be completed in full as failure to do so will result in your application form being returned to you and delays in your assessment being carried out.***

**Section 1 – Applicant Details (person with a disability)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Have you previously registered with HSE National Intellectual / Physical and Sensory Disability database? | | | | | Yes  No  Unsure | | |
| If you answered no, would you like a member of the HSE database department to contact you? | | | | | Yes  No  Unsure | | |
|  | | | | | | | |
| Title | | Mr.  Mrs.  Miss  Ms.  Dr.  Other | | | | | |
| Gender | | Male  Female | | | | | |
| First Name | |  | | Last Name | |  | |
| Postal Address | | |  | | | | |
| Country of Birth | | |  | | | | |
| Home Phone | | |  | Mobile Phone | | |  |
| DOB | | |  |  | | |  |
| Disability: | Physical & Sensory  Intellectual Disability  Both | | | | | | |
| Please provide details: | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If you live with family, does a parent / guardian / relative / friend receive the Carer’s Allowance for your care? | | | | | | | | | | | Yes  No | |
| Do you currently live with anyone who has a disability or depends on your main carer for care? | | | | | | | | | | | Yes  No | |
| **If you answered Yes, please provide details below.** | | | | | | | | | | | | |
| Person/s with a disability living with you | | | | | | | | | | | | |
| **Name (optional)** | | | | **Age** | | | **Relationship to Applicant** | | | | | **Disability Type** |
|  | | | |  | | |  | | | | |  |
|  | | | |  | | |  | | | | |  |
|  | | | |  | | |  | | | | |  |
|  | | | | | | | | | | | | |
| **Is this application form being completed by you?** | | | | | | | | | Yes  No | | | |
| If you answered No, please provide the details of the person who assisted you in completed this form and their relationship to you. | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| Do you need help with decision-making? | | | | | | | | | Yes  No | | | |
| If you answered Yes, please tick ☑ their relationship to you and provide their details below. | | | | | | | | | | | | |
| Parent  Formal Guardian  Advocate  Non-parent informal decision maker (please specify, e.g. sibling, friend) | | | | | | | | | | | | |
| **Decision-Maker 1** | | | | | | | | | | | | |
| Title | Mr.  Mrs.  Miss  Ms.  Dr.  Other | | | | | | | | | | | |
| First Name |  | | | | | Last Name | |  | | | | |
| Address (if different from applicant) | | |  | | | | | | | | | |
| Home Phone | |  | | | Mobile Phone | | |  | | | | |
| **Is this person the primary contact person for you?** | | | | | | | | | | Yes  No | | |
| **Does more than one person assist you with decision-making?** | | | | | | | | | | Yes  No | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Decision-Maker 2** | | | | | | | |
| Title | Mr.  Mrs.  Miss  Ms.  Dr.  Other | | | | | | |
| First Name | |  | | | | Last Name |  |
| Address (if different from applicant) | | | |  | | | |
| Home Phone | | |  | | Mobile Phone | |  |

**Section 2 - Support Required**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Activity | Requires full assistance of another person | Requires prompting & physical help | Requires continuous verbal prompting | Requires prompting only | Independent or uses aids only |
| **Self-Care / Management**  (e.g. personal hygiene and/or grooming, daily routines such as dental care, dressing) |  |  |  |  |  |
| **Social Interactions / Relationships**  (e.g. interpersonal skills / making friends, social relationships) |  |  |  |  |  |
| **Communication**  (e.g. being understood by others / understanding others) |  |  |  |  |  |
| **Mobility**  (e.g. moving around house / community, including accessing transport, getting from place to place) |  |  |  |  |  |
| **Learning / Applying Knowledge**  (e.g. understanding new ideas, problem-solving) |  |  |  |  |  |
| **Safety Awareness**  (e.g. road, fire, medications, danger, hazards) |  |  |  |  |  |
| **Community Participation**  (e.g. recreation, leisure, clubs, spirituality, services) |  |  |  |  |  |
| **Maintaining a Tenancy**  (e.g. managing relationships with neighbours, landlord) |  |  |  |  |  |
| **Budgeting or Handling Money**  (e.g. using, understanding and managing of money) |  |  |  |  |  |
| **Domestic / Household Duties**  (e.g. meal preparation, cleaning, shopping) |  |  |  |  |  |
| **Behaviour Support Required**  (e.g. coping with feelings / emotions, reducing disturbing or dangerous behavoiurs) |  |  |  |  |  |
| **Health / Medical Care**  (e.g. physical fitness, special care such as postural drainage, nasogastric care) |  |  |  |  |  |
| **Linking with Agencies & Services** |  |  |  |  |  |
| **Caring for a Dependent**  (e.g. dependent child or elderly parent) |  |  |  |  |  |
| **Planning for the Future**  (e.g. setting goals, establishing networks) |  |  |  |  |  |
| **Other**  (please specify) |  |  |  |  |  |
|  | | | | | |

**Section 3 – Education / Employment**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you between 4 and 18 years of age? | | | Yes  No | |
| Are you attending school? | | | Yes  No | |
| If Yes, school name |  | Hours per week | |  |
| **If you are not attending school, or are attending school less than full-time, please provide the reason/s why**. (e.g. graduated, suspended, complex medical issues) | | | | |
|  | | | | |

|  |  |
| --- | --- |
| **Are you in receipt of a Domiciliary Care Allowance?** | Yes  No |

|  |  |  |
| --- | --- | --- |
| Are you older than 18 years of age? |  | Yes  No |

|  |  |
| --- | --- |
| Please tick ☑ below any circumstances that you have or will experience this year. | |
| Left or leaving a Special School Education Programme  Ineligible for extension of current service  Unable to access further education / work  Are you attending a training programme, if so please provide the details, e.g. start time / finish time, number of days and hours each week. | Unable to access vocational / rehabilitative training  Exiting the care of the HSE (e.g. Foster Care)  None of the above or not applicable  Are you in or have you been offered a day placement?  Unable to access vocational / rehabilitation training |

|  |  |  |
| --- | --- | --- |
| Are you currently employed? |  | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Are you in receipt of a Disability Allowance?** |  | Yes  No |

|  |
| --- |
| Please provide details of the positive things in your life and strengths of your support network. (e.g. participation in hobbies, sports and other interests, pair or volunteer work, sibling have a strong friendship) |

Please attach a separate page if needed.

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**Section 4 – Services Currently Involved in Your Care**

|  |  |  |
| --- | --- | --- |
| **Provider Name** | **No. Of Hours of Support Per Week** | **Duties Carried Out - For example household, personal care, transport, etc.** |
| Centre for Independent Living |  |  |
| Irish Wheelchair Association |  |  |
| Acquired Brain Injury |  |  |
| Home Help Services / Package of Care |  |  |
| Jack & Jill Foundation |  |  |
| GALRO |  |  |
| RehabCare |  |  |
| National Learning Network |  |  |
| Deaf Hear |  |  |
| National Council for the Blind |  |  |
| Carers Association |  |  |
| Muíriosa Foundation |  |  |
| St. Hilda’s Service |  |  |
| St. Christopher’s Service |  |  |
| St. Anne’s Service |  |  |
| St. Cronin’s Service |  |  |
| Phoenix Centre |  |  |
| Springfield Centre |  |  |
| Clonbrusk Centre |  |  |
| HSE Community Respite or HSE Personal Care Support |  |  |
| Public Health Nursing |  |  |
| Occupational Therapy |  |  |
| Speech & Language Therapy |  |  |
| Physiotherapy |  |  |
| Mental Health Services / CAMHS |  |  |
| Psychology |  |  |
| Social Worker |  |  |
| Other / Paying Privately |  |  |

**Section 5 – General Information**

|  |
| --- |
| **If there is any additional information you would like to provide with your application, please provide details below.** (Information relating to the applicant or their immediate family situation e.g. financial pressure, relationship strain, work demands, other family members/s care needs. Barriers to support, social and geographical isolation.) |

Please attach a separate page if needed.

|  |
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|  |

**Section 6 – Confirmation and Consent**

|  |
| --- |
| This application for support must be signed and dated to enable the HSE to meet it’s statutory and regulatory oblications.  The confirmation acts as a declaration that, to the best of the signatory or their representative’s knowledge, the information contained within this application form is true at the time of completion. This consent acts as an approval for the HSE to provide personal information to agencies and practitioners, and as consent for those agencies and practitioners to provide personal information to the HSE for the purpose of planning and linking the applicant to supports, if appropriate.  If you do not consent to sharing information, the application from will still be processed, but it may limit the types of support and assistance that can be offered. Service may not be possible in the absence of consent to share.  The HSE will not release information without the consent of the applicant or their appropriate decision-maker. |

|  |  |  |  |
| --- | --- | --- | --- |
| Please confirm below that the information contained in this application is, to the best of the signatory’ knowledge, true at the time of completion and tick ☑ the relevant box below to indicate what level of consent is provided for release of information. Provision of false misleading information may result in suspension or loss of services.  I do not give consent  I am not authorised to give consent  I give consent for the HSE to contact the relevant agencies and practitioners and for them to share information in order to assess this application in planning / monitoring / reviewing and linking me to supports if appropriate.  Please tick this box to confirm that the information contained in this application is, to the best of your knowledge, true at the time of completion and that you understand non-identifiable information may be released for statistical purposes. | | | |
| Applicant Name  (please print) |  | Signature |  |
| Date Signed |  |  |  |

In the event the applicant is unable to sign, authorised signature on their behalf:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name  (please print) |  | | Signature |  |
| Relationship to applicant | |  | | |
| Date Signed |  | |  |  |

The consent provided on this form is valid until withdrawn and may be withdrawn at any time by notice in writing to Disability Services, Health Centre, Arden Road, Tullamore, Co. Offaly for the consenting person.

**Section 7 – Main Carer/s Details**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Carer 1** Title | | Mr.  Mrs.  Miss  Ms.  Dr.  Other | | | | | | | |
| First Name |  | | | | Last Name | |  | | |
| Address (if different from applicant) | | |  | | | | | | |
| Home Phone | | |  | | Mobile Phone | | |  | |
| **Relationship to applicant** | | | |  | | DOB | |  | |
| **Do you provide care to someone else as well as the applicant?**  (e.g. baby/toddler, aging parent, unwell family member) | | | | | | | | | Yes  No |

Only complete if there is a second carer.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Carer 2** Title | | Mr.  Mrs.  Miss  Ms.  Dr.  Other | | | | | | | |
| First Name |  | | | | Last Name | |  | | |
| Address (if different from applicant) | | |  | | | | | | |
| Home Phone | | |  | | Mobile Phone | | |  | |
| **Relationship to applicant** | | | |  | | DOB | |  | |
| **Do you provide care to someone else as well as the applicant?**  (e.g. baby/toddler, aging parent, unwell family member) | | | | | | | | | Yes  No |

|  |  |  |
| --- | --- | --- |
| **Are you experiencing difficulty in continuing to provide care?** | Yes  No | |
| **Please include why and when this is likely to occur.**  (e.g. carer’s age / health, work commitments, siblings needs) | | |
|  |  | |
| As main carer, please list the type of support you are providing | | Hours per week |
|  | |  |
|  | |  |
|  | |  |

**Section 8 – Other**

|  |  |  |
| --- | --- | --- |
| **Please tick ☑ the box below that best describes the support you usually receive from family or friends.** | | |
| **Most or all** of the support that I receive is from family and friends  I receive **occasional support** from family and friends  I receive support from family and friends **only in times of emergency** | | |
| **Please tick ☑ the box below that best describes your caring situation** | |  |
| Sole carer (e.g. single parent spouse)  Shares care | Young carer/s (e.g. under 18 years)  Elderly carer/s (e.g. carer over 70 years of age) | |

**Section 9 – Carer Consent**

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| --- |
| **Confirmation and Consent from the Carer**  This application for support must be signed and dated to enable the HSE to meet its statutory and regulatory obligations.  This confirmation acts as a declaration that, to the best of the signatory or their representative’s knowledge, the information contained within this application form is true at the time of completion. This consent acts as an approval for the HSE to provide personal information to agencies and practitioners, and as consent for those agencies and practitioners to provide personal information to the HSE for the purpose of planning and linking the applicant to supports, if appropriate.  If you do not consent to sharing information, the application form will still be processed but it may limit the types of support and assistance that can be offered.  The HSE will not release information without the consent of the applicant or their appropriate decision-maker. Consent to release information cannot be given by any person other than the applicant or their decision-maker. |

|  |  |  |  |
| --- | --- | --- | --- |
| Please confirm below that the information contained in this application is, to the best of the signatory’s knowledge, true at the time of completion and tick ☑ the relevant box below to indicate what level of consent is provided for release of information. The provision of false or misleading information may result in the suspension or loss of services.  I do not give consent  I am not authorised to give consent  I give consent for the HSE to contact the relevant agencies and practitioners for them to share information in order to assess this application in planning and linking me to supports if appropriate.  Please tick this box to confirm that the information contained in this application is, to the best of your knowledge, true at the time of completion and that you understand non-identifiable information may be release for statistical purposes. | | | |
| Carer 1 Name  (please print) |  | Signature |  |
| Date Signed |  |  |  |
| Carer 2 Name  (please print) |  | Signature |  |
| Date Signed |  |  |  |

The consent provided on this form is valid until withdrawn and may be withdrawn at any time by notice in writing to Disability Services, Health Centre, Arden Road, Tullamore, Co. Offaly for the consenting person.

**Section 10 – Additional Information**

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|  |