Application form for

Partial Capacity Benefit

Social Welfare Services
PCB 1
Data Classification R

What is Partial Capacity Benefit?

Partial Capacity Benefit (PCB) is a scheme available to people who have a restriction on their capacity to work. They can be medically assessed as having a mild, moderate, severe or profound restriction.

Mild restriction:	they do not qualify for payment
Moderate restriction:	receive 50% of their underlying entitlement
Severe restriction:	receive 75% of their underlying entitlement
Profound restriction:	receive 100% of their underlying entitlement

There is no restriction as to the number of hours or days worked.

What are the qualifying criteria?

Partial Capacity Benefit has two qualifying schemes:

- Customers who qualify having been in receipt of Invalidity Pension; and
- Customers who qualify having been in receipt of Illness Benefit for a minimum of 6 months.

To qualify for PCB, a customer:

- Must be in receipt of either Invalidity Pension (no minimum period), or Illness Benefit for a period of 6 months;
- Must be under 66 years of age;
- Must have a moderate, severe or profound restriction on their capacity to work. This is determined by a Department Medical Assessor who reviews information provided by your doctor and makes an assessment on your capacity to work.
- Your application must be received prior to you starting work. The Department may accept your application if it is received within 21 days of starting work.

How long does entitlement last?

For **Invalidity Pension** customers entitlement lasts for 156 weeks. Once this period has elapsed, customers can re-apply for a further 156 weeks.

For **Illness Benefit** (IB) recipients entitlement to PCB lasts for as long as entitlement to Illness Benefit remains. IB can be paid for 624 days. A customer must be on IB for 6 months before applying; therefore, the maximum duration that an Illness Benefit customer can remain on IB is 468 days, or 18 months.

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. Please:

- Write with a **black** ballpoint pen, use capital letters and place an **X** in the relevant boxes;
- Answer **all** questions;
- Remember to include any supporting medical evidence as requested in **Part 7**;
- Ensure that you sign **Part 1**, **Part 8** and **Part 9**, giving your doctor permission to give this department the necessary medical information required for your application; and
- Ensure that your doctor completes **Part 10** and supplies any supporting medical evidence which should be returned with your application form.

How can I get help and further information?

If you need any help to complete this form, please contact 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/PCB**

Doctor:
Please fill in the medical report at **Part 10** and enclose any up to date medical evidence in support of this application. Also please make sure you sign and stamp **Part 10**.

How to fill in this review form

To help us process this form please write letters and numbers clearly and use one box for each. See examples below.

Part 1 Your details

1. PPS Number: 1 2 3 4 5 6 7 T — ID Verified ☐ Yes ☒ No

2. Title, insert an **X** or specify: Mr ☐ Mrs ☒ Ms ☐ Other

3. Surname: MURPHY

4. First names: MAUREEN

5. First name as it appears on your birth certificate: MARY

6. Birth surname if different: MCDERMOTT

7. Mother's birth surname: KELLY

8. Date of birth: 28 02 1970 (D D M M Y Y Y Y)

9. Address: 1 NEWSTREET
OLD TOWN
DONEGAL TOWN
County DONEGAL Eircode C15A96V

10. Telephone number: 0881234567 MOBILE
0539312345 LANDLINE

11. Email address: MMURPHY@WELFARE.IE

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Application form for
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Part 1 Your details

1. PPS Number: ID Verified Yes No

2. Title, insert an **X** or specify: Mr Mrs Ms Other

3. Surname:

4. First names:

5. First name as it appears on your birth certificate:

6. Birth surname if different:

7. Mother's birth surname:

8. Date of birth:
D D M M Y Y Y Y

9. Address:

County Eircode

10. Telephone number:
MOBILE
LANDLINE

11. Email address:

12. Are you?

- Single
- Married
- Separated
- Divorced
- Widowed
- Cohabiting
- In a Civil Partnership
- A surviving Civil Partner
- A former Civil Partner (you were in a Civil Partnership that has since been dissolved)

13. If you are married, in a civil partnership or a civil union or cohabiting, from what date?
D D M M Y Y Y Y

Part 2 Your work and claim details

14. If you are getting any payment from this department or the Health Service Executive (HSE), please state:

Name of payment::

Amount: € ,. a week

15. What is your expected return to work date?

D D M M Y Y Y Y

Part 3 Your payment details

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

You will find the following details 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:

Note: Your Personal Public Service (PPS) number may be used to identify your payment to you.

Part 4 Details of your qualified children

You may be entitled to an increase in benefit for your children. The conditions of this increase remain the same as those that applied to your Illness Benefit or Invalidity Pension claim. For more information, visit **www.gov.ie/dsp**.

If you wish to claim the increase, complete this part of the form. **Parts 5** and **6** must also be completed in full and proof of income must be provided.

16. How many children do you wish to claim for?

☐☐ under age 18

☐☐ age 18 - 22 in full-time education

Please state child's:

Child 1

Surname:

First name:

PPS Number:

Date of birth:

D D M M Y Y Y Y

Relationship to you:

Does the child live with you? ☐ Yes ☐ No

Child 2

Surname:

First name:

PPS Number:

Date of birth:

D D M M Y Y Y Y

Relationship to you:

Does the child live with you? ☐ Yes ☐ No

Child 3

Surname:

First name:

PPS Number:

Date of birth:

D D M M Y Y Y Y

Relationship to you:

Does the child live with you? ☐ Yes ☐ No

Part 4 continued — Details of your qualified children

Child 4

Surname:

First name:

PPS Number:

Date of birth:

D D M M Y Y Y Y

Relationship to you:

Does the child live with you? ☐ Yes ☐ No

Child 5

Surname:

First name:

PPS Number:

Date of birth:

D D M M Y Y Y Y

Relationship to you:

Does the child live with you? ☐ Yes ☐ No

Note: A separate sheet of paper can be used for details of other children you have.

17. Are any of the children named above getting a payment from this Department or the Health Service Executive (HSE)?

If **yes**, please state:

Child's surname:

Child's first names:

Name of payment:

Amount: € . a week

Part 5 Your spouse, civil partner or cohabitant's details

You may be entitled to an increase in benefit for your spouse, civil partner or cohabitant. The conditions of this increase remain the same as those that applied to your Illness Benefit or Invalidity Pension claim. For more information, visit **www.gov.ie/dsp**.

18. Their PPS Number: ID Verified ☐ Yes ☐ No

19. Title, insert an **X** or specify: Mr ☐ Mrs ☐ Ms ☐ Other

20. Their surname:

21. Their first names:

22. Birth surname if different:

23. Their mother's birth surname:

24. Their date of birth:

D D M M Y Y Y Y

25. Their address:

County Eircode

Only answer the above question if you are married or in a civil partnership and do not live together.

26. Do you wish to claim an increase for them? ☐ Yes ☐ No

If **yes**, please complete fully the remainder of this part of the form and **Part 6**.

If **no**, please go to **Part 7**.

27. Do they live in another EU country? ☐ Yes ☐ No

28. Their nationality:

29. Their country of birth:

30. If they do not live with you, are you paying them maintenance? ☐ Yes ☐ No

If **yes**, please state:

Amount of maintenance being paid: € ☐,☐☐☐.☐☐ a week

Part 6 Your spouse's, civil partner's or cohabitant's work and claim details

31. Are they employed at present? ☐ Yes ☐ No

If **yes**, please state:

Employer's name:

Employer's address:

County Eircode

Gross income: € , . a week

Please attach 3 of their most recent payslips.

32. Are they self-employed, including farming, at present? ☐ Yes ☐ No

If **yes**, please state:

Type of work they do:

Date they started self-employement:

D D M M Y Y Y Y

Net earnings: € , . a year

If self-employed, please supply the most recent set of accounts.

33. Are they getting any payment or pension from this Department or the Health Service Executive, apart from child benefit? ☐ Yes ☐ No

If **yes**, please state:

Type of payment:

Their claim or reference number :

Amount: € , . a week

Does this payment or pension include an increase for you? ☐ Yes ☐ No

34. Are they getting a pension or allowance from another country? ☐ Yes ☐ No

If **yes**, please state:

Name of country:

Their claim or reference number :

Amount: € , . a week

Does this payment or pension include an increase for you? ☐ Yes ☐ No

If they are getting a payment, please attach the most recent payslips, statements or letters from the people who pay confirming the above amounts. Also provide three months' bank statements for the account to which the payments are made.

Part 6 continued

Your spouse's, civil partner's or cohabitant's work and claim details

35. a) Please indicate if they are taking part in any of the following courses or schemes. Insert an **X** in the box as it applies to them and provide the start date, if applicable.

			Start date:
Community employment:	☐ Yes	☐ No	D D M M Y Y Y Y
Rural Social Scheme:	☐ Yes	☐ No	D D M M Y Y Y Y
Area-based initiative:	☐ Yes	☐ No	D D M M Y Y Y Y
Back to Work scheme:	☐ Yes	☐ No	D D M M Y Y Y Y
Vocational Training Opportunities Scheme:	☐ Yes	☐ No	D D M M Y Y Y Y
Back to Education Allowance:	☐ Yes	☐ No	D D M M Y Y Y Y
Community Services Programme:	☐ Yes	☐ No	D D M M Y Y Y Y
Tús:	☐ Yes	☐ No	D D M M Y Y Y Y
Other course, such as a rehabilitative course:	☐ Yes	☐ No	D D M M Y Y Y Y
School or college:	☐ Yes	☐ No	D D M M Y Y Y Y

b) Please state what they get paid, if anything, for doing this course or scheme: € ☐,☐☐☐.☐☐ a week

36. Have they got any other source of income? ☐ Yes ☐ No

If **yes**, please give details:

Part 7 Additional information

In support of your application, it is advisable to enclose **any** additional medical evidence you may have.

37. Have you enclosed any additional medical evidence? ☐ Yes ☐ No

If **yes**, please give details:

38. Have you signed the declaration in **Part 9** giving permission to ask your doctor to release your medical information to this Department? ☐ Yes ☐ No

If your form is not fully completed or the documents required are not enclosed there will be a delay in deciding your claim for Partial Capacity Benefit.

Your application cannot be processed without the medical report being completed and returned.

Please remember to sign the Declarations in Parts 8 and 9.

Send the completed application form and other related documents to:

Partial Capacity Benefit Section
Department of Social Protection
Government Buildings
Ballinalee Road
Longford

Telephone: (043) 334 0000 or 0818 927 770

If you are calling from outside of Ireland please call + 353 43 334 0000

Email: PCB@welfare.ie

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.

Part 8 Personal questionnaire

You should complete this 'Personal Questionnaire' to support your application.

Describe how your condition affects your activities during a typical day, as outlined below.
If necessary, please use an additional sheet of paper.

- **Mental health**, for example, impaired attention, concentration, poor memory and fatigue, coping with pressure and interacting with people, disturbed sleep pattern.

  ☐ Yes ☐ No

  If **yes**, please give details:

- **Physical health**, for example, standing, sitting, bending, squatting, lifting or carrying, reaching, climbing stairs or ladders, using public transport.

  ☐ Yes ☐ No

  If **yes**, please give details:

Continued on the next page

Additional information

- **Self-care**, for example, washing, eating, dressing or toileting. ☐ Yes ☐ No

  If **yes**, please give details:

- **Home and family care**, for example, housework, shopping, cooking or DIY. ☐ Yes ☐ No

  If **yes**, please give details:

- **Manual dexterity**, for example, picking up small items, writing, or using a computer. ☐ Yes ☐ No

  If **yes**, please give details:

- **Communication or sensory**, for example, speech, hearing, seeing. ☐ Yes ☐ No

  If **yes**, please give details:

- **Hobbies and leisure**, for example, sports, reading or watching TV. ☐ Yes ☐ No

  If **yes**, please give details:

Please provide any further relevant information:

Part 8 continued

Additional information

Please provide any further relevant information:

Date: D D M M 2 0 Y Y Y Y

Signature, **not** in capital letters.

Your PPS Number:

The information provided will be treated with the strictest confidence.

Medical report for

Partial Capacity Benefit

Part 9 Permission to release medical information

Please sign the authorisation below, which will allow your doctor to give this Department the necessary medical information for your application for Partial Capacity Benefit. **Your doctor should then complete Part 10 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.

I permit my doctor to provide you, the Department of Social Protection, with medical information that may be required for my application for Partial Capacity Benefit.

Signature, **not** capital letters.

Date: D D M M 2 0 Y Y Y Y

If you are unable to sign, have your mark witnessed and have the witness sign below for you:

Witness signature, **not** capital letters.

Date: D D M M 2 0 Y Y Y Y

Part 10 Medical report

Dear Doctor,

To enable us, on behalf of your patient, to accurately assess their eligibility or continued eligibility for Partial Capacity Benefit, please complete the medical report on the next page. The medical information provided will be reviewed by our medical assessors and will be handled in strictest confidence. Although a confidential document, both medical and non-medical people will need to deal with this report.

You can get a special fee for completing and returning this report. To ensure payment please enter your DSP panel number in the box provided. If you prefer to return the report directly to the Department, please send it to: FREEPOST, Partial Capacity Benefit Section, Department of Social Protection, Government Buildings, Ballinalee Road, Longford.

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.

Medical report

1. Patient details:

Note: Please use CAPITAL LETTERS

Surname:

First names:

Address:

County

Eircode

Date of birth:

D D M M Y Y Y Y

PPS number:

Occupation:

Telephone number:

If a mobile number, the patient may be contacted by text message in relation to a medical assessment.

2. Your patient since:

D D M M Y Y Y Y

3. Diagnosis or diagnoses:

4. ICD10 Code(s):

5. Date condition started:

D D M M Y Y 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 details of the following:

Medical history:

Surgical/Obstetrical history:

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**, please give the expected date of delivery (EDD):

				2	0		
D	D	M	M	Y	Y	Y	Y

Please attach any relevant reports or results of investigations.

Additional information:

Ability or 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	☐	☐	☐	☐	☐
Learning and intelligence	☐	☐	☐	☐	☐
Consciousness and seizures	☐	☐	☐	☐	☐
Balance and co-ordination	☐	☐	☐	☐	☐
Vision	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Speech	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐
Manual Dexterity	☐	☐	☐	☐	☐
Lifting and carrying	☐	☐	☐	☐	☐
Bending, kneeling and squatting	☐	☐	☐	☐	☐
Sitting and rising	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Climbing stairs and ladders	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐

11. A Medical Assessment by one of the Department's Medical Assessors may be required to determine continued eligibility for Illness benefit or Invalidity Pension and eligibility for Partial Capacity Benefit.

Is your patient fit to attend a medical assessment? ☐ Yes ☐ No

If **no**, please give details:

Medical report

Doctor's details

Doctor's name:

DSP panel number:

IMC number:

Address:

County

Eircode

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

Doctor's official stamp

Date: D D M M 2 0 Y Y Y Y

Note: Both doctor's signature **and** doctor's official stamp are required.

For official use only

i) Assessed restriction on the person's capacity for work:

- Mild ☐
- Moderate ☐
- Severe ☐
- Profound ☐

ii) Eligible for Partial Capacity Benefit: ☐

iii) Review: ☐

iv) DNRA: ☐

v) Not eligible for Partial Capacity Benefit: ☐

Give reasons: ☐

vi) Refer for in-person assessment regarding continued entitlement to Illness Benefit or Invalidity Pension and category of restriction: ☐

Signed: _____ **Medical Assessor**

Date: ☐☐ ☐☐ 2 0 ☐☐

D D M M Y Y Y Y

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