Claim Form for Blind Welfare Allowance (BWA)

(BWA V08/2005)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

For Office Use
Date Received

By Whom

In order to assess your entitlement correctly please

- **Use BLOCK LETTERS. Answer all questions fully, as incomplete information may delay processing your claim.**
- **Read and sign the Declaration.**
- **Take the completed form together with evidence of Income to your local Health Service Executive Office.**
- **Supply a full length Birth Certificate for each person who does not already have a P.P.S. No.**
- **Supply details of your Blind Pension or confirmation that you are registered with the National Council for the Blind or a certificate of visual impairment from an Opthalmic Surgeon/Physician as indicated at part 7.**

If you have difficulty in completing this form please contact the Community Welfare Officer at your local Health Centre.

Part 1 Applicant's Details

Surname______________________________ **P.P.S. No.** ☐☐☐☐☐☐☐☐☐

First Name______________________________

Address____

Telephone No.____________________________ **Date of Birth**__________________

Do you have a Social Security Number from another country? **Yes** ☐ **No** ☐

If "YES" please state: Number________________ **Country**________________

State your Birth Surname:______________________________________

Are you (please tick (✔) as appropriate): Male ☐ **Female** ☐

Single ☐ **Married** ☐ **Separated** ☐ **Widowed** ☐ **Cohabiting** ☐ **Divorced** ☐

Part 2 Your Spouse/Partner's Details

Full Name________________________________ P.P.S. No. | | | | | | | | | |

Address____

________________________________ Date of Birth____________

Does he/she have a Social Security Number from another country? Yes ☐ No ☐

If "YES" please state: Number______________ Country______________

State his/her Birth Surname:______________________________

Part 3 Child Dependant Details

Please give details of children under 23 years of age who are dependent on you.

Child's Name		Date of Birth	P.P.S. No.	Relationship to you	Does the child live with you Yes/No
First Name	Surname				

Part 4 Incomes Awaited

Are you or your spouse/partner awaiting income from:

Source	Yourself		Spouse/Partner		Details
	Yes	No	Yes	No	
A Social Welfare Claim					
Employment/Redundancy Payments					
A Social Security Claim to another State					
A Maintenance Order/Application					
A Pension Application					
A Compensation Claim					
Any Other Source					

Part 5 Details of Means

A. How much income per week do you and your spouse/partner have from the following sources?

Source	Yourself €	Spouse/Partner €	Details
Social Welfare Payments			
Health Service Executive Payments			
Social Security Claim from another State			
Wages/Salary			
Self Employment (including farming)			
Sick Pay/Income Protection Schemes			
Occupational Pension(s)			
Maintenance Payments			
FAS Training Allowance			
Strike Pay			
Any other source(s) - Please specify			

B. Have you or your spouse/partner investments in stocks, shares, or deposits with Banks/Building Societies or other Financial Institutions? **Yes** ☐ **No** ☐

If "yes" please provide details of:

Amount(s) € ____________________ **Where invested** ____________________

C. Do you or your spouse/partner own any property (including land) other than the house you occupy? **Yes** ☐ **No** ☐

If yes, please give the location and use of the property ____________________

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Part 6 Employment/Educational Schemes

How much are you or your spouse/partner in receipt of per week from the following Schemes?

	Yourself €	Spouse/ Partner €
Area Based Initiative / Back to Work Allowance		
Revenue Job Assistance / Back to Education Allowance		
Community Employment Scheme / Other Scheme		
When did the payment(s) commence? (Date)		

Part 7 Employment/Educational Schemes

A. Are you in receipt of a Blind Pension from the Department of Social and Family Affairs? If yes, please provide the following details:-

Amount: €________________ Claim Number:________________

B. If you are registered with the National Council for the Blind of Ireland, please provide confirmation of your registration. Otherwise, please provide a qualifying Certificate of Visual Acuity from your Ophthalmic Surgeon/Physician.

C. Are you currently in hospital or a long term care facility Yes ☐ No ☐

Name of Hospital/facility________________________________

Date of admission________________________________

Part 8 Declaration

I declare that the information given by me in this application is complete and accurate. I undertake to advise the Health Service Executive immediately of any changes in circumstances including changes in income(s), dependency, address and/or any such changes relating to my spouse/partner which may occur affecting my eligibility for Blind Welfare Allowance.

I authorise the Health Service Executive to make all enquiries necessary to establish my current eligibility status including access to Social Welfare computer data and/or that of my spouse/partner and to make such enquiries as may be necessary on an on-going basis for review purposes.

I understand that if I am dissatisfied with a decision on my claim, I have a RIGHT OF APPEAL.

I am aware of the content of this application and knowingly make this declaration

Signature of applicant____________________________________ Date______________

If the applicant is unable to sign, his/her mark should be made and witnessed. The Witness should sign below.

Signature of witness____________________________________ Date______________

It is an offence to give false or misleading information.
Information may be shared with other bodies in accordance with law.

OFFICE USE ONLY

REPORT

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A. Applicant's total Assessable Income (applicant + spouse/partner's income ÷ 2) €______________________

B. Blind Pension Single Rate + appropriate
Blind Pension CDA Rate €______________________
\+
BWA Rate €______________________

Total €______________________

C. Deduct **B** from **A** = €______________________
(Excess)

D. Deduct Excess (€) from B.W.A. Rate (€) = €______________________
(B.W.A. payable in respect of applicant)

E. Add on the appropriate Child Dependant
Rate of B.W.A. in respect of each child dependent €______________________

F. Add **D** to **E** = €______________________
Total weekly rate of B.W.A. payable

Signed:______________________ Date: ______________________

Approved/Disallowed ______________________ Authorised Officer:______________________