

CLAIM FORM FOR MOBILITY ALLOWANCE

(MOBALL V08/2005)

For Office Use

Date Received

By Whom



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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.
- Provide Medical Certification.

NB: You cannot avail of Mobility Allowance and Motorised Transport Grant simultaneously.

PART 1 APPLICANT'S DETAILS

SURNAME _____ P.P.S. NO.

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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.

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DATE OF BIRTH _____

ADDRESS _____

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 ALLOWANCE DETAILS

A. Have you received Motorised Transport Grant in the last 3 years? Yes No

If "yes" please give details of when received _____

NB: You cannot qualify for Mobility Allowance if you have received Motorised Transport Grant in the last 3 years.

B. Are you the holder of a Primary Medical Certificate and, therefore, availing of the Disabled Drivers and Disabled Passengers Tax Concessions Scheme? Yes No

NB: You can only obtain a maximum payment of 50% of the normal Mobility Allowance rate, payable if you are availing of the Disabled Drivers and Disabled Passengers Tax Concessions Scheme.

PART 5 DETAILS OF MEANS

A. How much income weekly 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) invested € _____ 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 _____

PART 6 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 7 EMPLOYMENT/EDUCATIONAL SCHEMES

How much are you or your spouse/partner in receipt of <u>weekly</u> 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 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 Mobility 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.**

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FOR COMPLETION BY AMO/SMO

A. What is the nature of the applicant's disability?

B. Does the applicant's disability conform with the medical criteria laid down for Mobility Allowance qualification? YES NO

Please describe: _____

Signed: _____ Date: _____

REPORT

A. Appropriate Disability Allowance rate (if applicant is under 66) or appropriate Non Contributory OAP rate (if recipient is over 66). € _____

B. Applicants assessable income € _____

C. Deduct A from B = € _____ (excess)

D. Deduct excess (€ _____) from Weekly Mobility Allowance rate* (€ _____) = € _____
Weekly Mobility Allowance payable

***NB Please note that 50% of the weekly Mobility Allowance rate should be applied if applicant is availing of the Disabled Drivers and Disabled Passengers Tax Concessions Scheme.**

Signed: _____ Date: _____

Approved/Disallowed Authorised Officer: _____