Application Form

Long-Term Illness (LTI) Scheme

Free drugs, medicines, medical and surgical appliances for certain long-term illnesses.

The Long-Term Illness Scheme applies only to people who have been diagnosed with one or more of the following long-term diseases or disabilities covered by this scheme:

Acute Leukaemia	Diabetes Mellitus Does not include Gestational Diabetes	Intellectual Disability (Described in legislation as Mental Handicap.)	Parkinsonism
Cerebral Palsy	Epilepsy	Mental Illness (Under 16 years)	Phenylketonuria
Cystic Fibrosis	Haemophilia	Multiple Sclerosis	Spina Bifida
Diabetes Insipidus	Hydrocephalus	Muscular Dystrophies	Thalidomide Conditions

There are two sections to this application form:

Section 1 - should be completed by the applicant (or by a parent or guardian signing on behalf of the applicant). Please ensure this section is completed in block capitals.

Section 2 - should be completed by a healthcare professional (for example, your GP or hospital consultant).

Completed application forms should be returned to your local community health organisation.

Section 1 – Applicant – Personal Details

First name(s):

Surname:

Date of birth: D D M M Y Y Y Y

Birth surname:
(If different)

PPS number:
(Mandatory)

Gender: Male Female

Address:

Mobile phone: –

(If you enter your mobile phone number, we may text you about your application.)

Daytime phone:

Email address:

Eircode: E I R – C O D E

Section 1A – Nominated Pharmacy

Name:	
Address:	
	(Please note this is optional.)

If you wish, you can give us the name of the pharmacy you use. This will allow us to get in touch with them if there is any drug-related information we need to share. If you would rather not name a pharmacy, just leave this area blank.

Section 1B – Your GP's details

Name:	
Address:	

Section 1C – Declaration and Consent

I am applying for eligibility under the Long-Term Illness Scheme.

I declare that the information I have given is correct to the best of my knowledge.

I agree that my pharmacist may contact the HSE to confirm that the prescribed medicines are approved under the scheme.

If it applies, I confirm that I am the parent or legal guardian of the named applicant, and I give consent on their behalf.

Signature:		**Date:**	D D M M Y Y Y Y

If you are signing on behalf of the applicant, please complete the details below	
Your name: Block Capitals	
Relationship to applicant:	

Section 1D – Data Protection and Freedom of Information Notice

The HSE will treat all personal information and data you provide as part of this application, as confidential and store it securely.

When the HSE receives the completed application form, it will make a computer record for the named applicant.

This record will contain the relevant personal information you have supplied.

This personal record will be used and kept by the HSE, solely for the purposes of processing your Long-Term Illness application.

The HSE will not disclose (share) to other people or organisations the personal information you have given unless consent has been given by the person authorised to give this consent, or if the HSE is required to do so by law.

Section 2 – Certification by General Practitioner or Hospital Consultant

I certify that Name:

has one or more of the prescribed diseases or disabilities of a permanent or long-term nature covered by Section(3) of the Health Act 1970 (as amended) that are listed on page 1.

Please tick all illnesses that apply as that will influence what drugs, medicines, medical and surgical appliances are provided free to the eligible person.

Acute Leukaemia		Diabetes Mellitus Does not include Gestational Diabetes		Intellectual Disability (Described in legislation as Mental Handicap.)		Parkinsonism	
Cerebral Palsy		Epilepsy		Mental Illness (Under 16 years)		Phenylketonuria	
Cystic Fibrosis		Haemophilia		Multiple Sclerosis		Spina Bifida	
Diabetes Insipidus		Hydrocephalus		Muscular Dystrophies		Thalidomide Conditions	

The following drugs, medicines, medical and surgical appliances are needed to treat the prescribed disease(s)/ disability:

Drug/Medicine (include strength and pharmaceutical form /Medical and surgical appliance*	
1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Signature:		Doctor's Stamp
	General Practitioner/Hospital Consultant	
Name:		
Medical Council No.	Date: D D M M Y Y Y Y	

* Non consumable surgical appliances (equipment) are organised through your Community Health Organisation (Local Office)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

For official use

LTI No. _____

Approval Date: _____

Official Use Only – Decision of Health Service Executive

The following drugs, medicines, medical and surgical appliances listed under the line items on page 3 of this form by the applicant's GP or hospital consultant are hereby **approved**.

Signed:													**Date:**	D	D	M	M	Y	Y	Y	Y
Authorised Officer													Contact No:								
Name:																					
GMS No. of pharmacy (if one is stated):																					

Date of approval:	D	D	M	M	Y	Y	Y	Y
Effective date of eligibility:	D	D	M	M	Y	Y	Y	Y
Date dispatched to Primary Care Reimbursement Service:	D	D	M	M	Y	Y	Y	Y
Date entered on local office LTI system:	D	D	M	M	Y	Y	Y	Y

Plain English
Approved by NALA