Department of Social Security

HM Government of Gibraltar

| Claim No. |
| --- |
| **Stamp and date of receipt** |

# Application form for Disability Benefit
# Application for an Adult

1. Please use BLOCK LETTERS and place a tick (✓) in the appropriate boxes.
2. Please answer all questions and if some do not apply to you draw a line through the answer.
3. Please submit, together with the application, any medical reports that you may have.
4. Please submit, together with the application, a photograph of person with disability.
5. Please note that to be eligible to apply you must be from the age of 18 to 59.
6. Please ensure to sign consent form in Part 6.
7. If you fail to answer questions, it could delay in processing your claim.
8. If you are completing the form on behalf of someone else, give details of the person with a disability and sign declaration in Part 5.
9. If you need help in filling this form, please ask a member of staff for assistance.
10. If you do not have all the required documents readily available, please do not delay in submitting your application form duly signed and dated. Claims will only be considered from **the date the application form is received, signed and dated, by the Department of Social Security.** Please note that no payments will be effected prior to the date of submission of your signed and dated application form.

## Part 1 : Particulars of person with disability

### Personal Details

| | |
|---|---|
| Full name | |
| Maiden name (if applicable) | |
| Address | |
| Period of residence in Gibraltar | |
| E-mail address | |
| Daytime telephone number | |
| Date of birth | / / |
| Place of birth | |
| Nationality | |
| ID card number | |
| Nature of Disability | |
| How long have you had this disability? | |

## Part 1 : Particulars of person with disability (continued)

### Employment

Are you in employment?

No ☐

Yes ☐

If you answered **Yes**, please state Employer's name and address

When did you start this employment? / /

What type of work do you do?

Your gross pay?

How many hours do you work per week?

Are you engaged under a Government Training Scheme?

No ☐

Yes ☐

If you answered **Yes**, when did you start your training? / /

How many hours training do you do?

### Social History

Do you live alone?

No ☐

Yes ☐

If the answer is **No**, please state your current family composition

## Part 1 : Particulars of person with disability (continued)

| | |
|---|---|
| Please state your carer support arrangements | |

Do you receive Domiciliary Care?

No ☐

Yes ☐

| | |
|---|---|
| If the answer is **Yes**, please state whether the care is Private or supported by Social Services | |
| Please state how many hours per week | |

### Person's view of their health and social care needs (referrer's or persons own views)

(Nature of the problem; Impact on ability to self-care; Recent events or life changing situations; Other problems experienced)

### Medical Details

| | |
|---|---|
| Diagnosis | |

## Part 1 : Particulars of person with disability (continued)

Medical and mental health history

*(please provide us with your medical history, includes mental health, visual and hearing impairments)*

Current medication

*(please affix photocopy of current prescription, if available)*

### Personal Independence- Mobility

Are you independent indoors?

No ☐

Yes ☐

If you answered **No**, please provide details

Are you independent outdoors?

No ☐

Yes ☐

If you answered **No**, please provide details

Do you require help with walking?

No ☐

Yes ☐

## Part 1 : Particulars of person with disability (continued)

| | |
|---|---|
| How far can you walk before feeling severe discomfort/pain? | |

| | | |
|---|---|---|
| Stair Mobility: Are you independent on stairs? | No | ☐ |
| | Yes | ☐ |
| Do you have stairs in your home, or at entrance to home? | No | ☐ |
| | Yes | ☐ |
| Do you suffer from frequent falls or loss of balance? | No | ☐ |
| | Yes | ☐ |
| Have you been referred to Falls Assessment at the GHA? | No | ☐ |
| | Yes | ☐ |

| | |
|---|---|
| How do you currently get to Food Shops, to the Bank, Leisure Activities? | |
| What transport do you use? | |

### Special Equipment

**Describe the type of equipment you currently use which assists you with your independence? Please indicate the type used.** For example: mobility equipment (e.g. walking frame or wheelchair), portable oxygen, communication devices, manual handling equipment (e.g. hoist), or any other.

| Type of Equipment |
|---|
| |
| |
| |
| |

## Part 1 : Particulars of person with disability (continued)

### Personal Care

**Please indicate if you have difficulties or require support with any of the following? If answer is Yes please explain in comment box.**

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Getting on/off chair | | | |
| Toileting | | | |
| Getting on/off toilet | | | |
| Attending to personal hygiene | | | |
| Grooming (hair, shaving) | | | |
| Bathing | | | |
| Showering | | | |
| Dressing | | | |
| Feeding | | | |
| Drinking | | | |
| Sleeping | | | |
| Getting on/off bed | | | |
| Ability to adjust position in bed | | | |
| Night time positioning | | | |
| Ability to manage pressure areas | | | |
| Ability to manage medications (as precribed) | | | |

## Part 1 : Particulars of person with disability (continued)

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Other | | | |
| Which of the above is the most difficult for you to carry out without help, and the reasons why? | | | |

### Daily Living Activities

**Please indicate if you have difficulties or require support with any of the following? If answer is Yes please explain in comment box.**

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Meal Preparation | | | |
| Cooking | | | |
| Drink preparation | | | |
| Disposing rubbish | | | |
| Light cleaning | | | |
| Heavy cleaning | | | |
| Laundry | | | |
| Other | | | |
| Which of the above is the most difficult for you to carry out without help, and the reasons why? | | | |

## Part 1 : Particulars of person with disability (continued)

### Community Activities

**Please indicate if you have difficulties or require support with any of the following? If answer is Yes please explain in comment box.**

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Visiting shops, pharmacy, post office, etc. | | | |
| Paying bills | | | |
| Attending appointments | | | |
| Attending social activities | | | |
| Other | | | |
| Which of the above is the most difficult for you to carry out without help, and the reasons why? | | | |

### Communication

**Please indicate if you have difficulties or require support with any of the following? If answer is Yes please explain in comment box.**

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Spoken | | | |
| Keyword (eg. Makaton) | | | |
| Sign language | | | |
| Written | | | |
| Symbols/pictures | | | |

## Part 1 : Particulars of person with disability (continued)

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Braille | | | |
| Limited communication | | | |
| No formal communication | | | |
| Do you need someone with you to help you communicate? | | | |

### Cognition

**Please indicate if you have difficulties or require support with any of the following? If answer is Yes please explain in comment box.**

| | Difficulty | | Comments |
|---|---|---|---|
| | Yes | No | |
| Understanding | | | |
| Memory | | | |
| Problem solving | | | |
| Safety Awareness | | | |
| Awareness of difficulties | | | |
| Do you require supervision | | | |

| | |
|---|---|
| What are your concerns, if any, about going out independently? | |

## Part 1 : Particulars of person with disability (continued)

### Health Professionals Involved In Your Care

**What health professional(s) do you see on a regular basis (please provide names) and what care provision do you receive from them? How often do you see them?**

| | **Details** |
|---|---|
| Occupational Therapist | |
| Physiotherapist | |
| Speech and Language Therapist | |
| District Nurses | |
| Mental Health Worker | |
| Psychologist | |
| Psychiatrist | |
| Social Worker | |
| Doctor/Consultant | |
| Rehabilitation Officer for the Visually Impaired | |

### Other Social Security Benefits You Might Be receiving

Are you in receipt of any social security benefit payable in Gibraltar, in the United Kingdom or a EU country?

No ☐

Yes ☐

If you answered **Yes**, please state type of benefit

Name of country that pays you

## Part 1 : Particulars of person with disability (continued)

Your social security number

Amount of payment you receive

Attach recent payslip or advice slip from the office issuing your payment to confirm you are getting this benefit.

Is any other person getting a social security benefit in respect of you?

No ☐

Yes ☐

If you answered **Yes**, please state name of person

## Part 2 : Bank details

### 1. Bank account or building society account of applicant.

Please provide details of the financial institution where you want your benefit payment to be made. You will find the account details on the chequebook, passbook or on the bank statements. If you do not have a bank account or building society account and you wish to have the benefit payment paid into someone else's bank account please go to section 2 below.

Full name of bank or building society

Name of the account holder (The account must be in your name or held jointly)

Sort code ☐☐ – ☐☐ – ☐☐

Account number ☐☐☐☐☐☐☐☐

**More information if it is a building society account**

If you are using a building society account you may need to tell us a roll or reference number. This may be made up of letter and numbers, and may be up to 18 characters long. If you are not sure if the account has a roll or reference number, ask the building society.

Building society account number

## Part 2 : Bank details (continued)

### 2. Bank details of third party

Bank account or building society account in which you have authorised payment of benefit to be made.
Please note that your benefit payment can be paid into someone else's account (third party). The account holder should be someone that you trust, usually a relative or close friend.

Please provide details of the third party account holder.

Full name of bank or building society

Name of the account holder

Sort code – –

Account number

**More information if it is a building society account**

If you are using a building society account you may need to tell us a roll or reference number. This may be made up of letter and numbers, and may be up to 18 characters long. If you are not sure if the account has a roll or reference number, ask the building society.

Building society account number

## Part 3 : Other information

**Use this space to tell us anything else you think we might need to know that may assist in awarding the benefit.**

You can continue on a separate piece of paper if you need to.
If you continue on a separate piece of paper, make sure you:

- Write your full name, address and ID card number on it and attach it to this application form.
- Sign and date it.

## Part 4 : Declaration signed by person with disability

**I declare** that all the statements on this form are true to the best of my knowledge and belief.

**I understand** that if I knowingly give information that is incorrect or incomplete, I may be liable to prosecution or other action.

**I understand** that it is an offence to fail to notify the Department of Social Security of a change in my medical or other circumstances promptly, and failure to do so may result in action being taken against me.

| | |
|---|---|
| Signature of person with disability | |
| Date | / / |

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## How we collect and use information

The Department of Social Security collects information for the purposes of dealing with social security benefits and other non-contributory benefits. The information we collect about you depends on the reason for your business with us, but we may use the information for any of these purposes.

We may check information about you with other information we have. We may get information about you from other people and certain other organisations. We may give information to certain other organisations, as the law allows, to:

- check the accuracy of information;
- prevent or detect crime;
- protect public funds in other ways; and
- use in research or statistics.

These other organisations include other government departments, local authorities, and private sector bodies such as banks and organisations that may lend you money. We will not give information about you to anyone outside our department unless the law allows us to.

The Department of Social Security is the data controller for the purposes of the Data Protection Act.

## Part 5 : Signing the form for someone else

| | |
|---|---|
| Full name | |
| Address | |
| E-mail address | |
| Daytime phone number | |
| Date of birth | / / |
| Your relationship to the person with disability on behalf of whom you are applying | |

**I wish** to apply for disability benefit for another adult.

**I declare** that all the statements on this form are true to the best of my knowledge and belief.

**I declare** that the person I am applying for is so ill or disabled that he/she finds it impossible to sign for himself/herself.

**I understand** that if I knowingly give information that is incorrect or incomplete, I may be liable to prosecution or other action.

**I understand** that it is an offence to fail to notify the Department of Social Security of a change in his/her medical or other circumstances promptly, and failure to do so may result in action being taken against me.

| | |
|---|---|
| Signature of person applying on behalf of person with disability | |
| Date | / / |

**Part 6 : Consent Form**

| Claim No. |
| --- |
| **Stamp and date of receipt** |

Department of Social Security
HM Government of Gibraltar

## CONSENT FORM

### Consent for the disclosure of medical and health records

| | |
| --- | --- |
| I *(state name of person giving consent)* | |
| of *(state address)* | |
| Date of Birth | / / |

hereby authorise the Department of Social Security to discuss with, and disclose any medical and health records that the Gibraltar Health Authority holds in respect of:

| | |
| --- | --- |
| State name of person whose medical records are to be disclosed | |
| Signature (of person giving consent) | |
| Date | / / |