



**DO NOT FILL OUT THIS SECTION - FOR OFFICIAL USE ONLY**

The purpose of this form is to make an application under the Health (Repayment Scheme) Act 2006

We the Scheme's Administrator and the HSE will treat all information and personal data which you provide as confidential. We will only disclose it to other bodies in accordance with law. We are responsible for your information under the Data Protection Act and the Freedom of Information Act.

**PLEASE READ THESE INSTRUCTIONS AND THE ATTACHED INFORMATION SHEET BEFORE COMPLETING THE FORM**

**PLEASE COMPLETE THIS FORM IN *BLACK PEN***

**If further information on completing this form is required please contact our lo-call Information Line at 1890 886 886 (Monday to Saturday, 8am to 9pm initially) or visit our website [www.repay.ie](http://www.repay.ie)**

***CLAIMS ON BEHALF OF LIVING PATIENTS***

- If you are making a claim **on behalf of yourself** please fill in **Section A, Section B, and Section C** where appropriate and **swear** this form on the last page.
- If you are making a claim **on behalf of a Patient who is living** please fill in **Section A, Section B, Section C** where appropriate, **Section D, and Section E**, and **swear** this form on the last page.

***CLAIMS BY LIVING SPOUSES AND CHILDREN***

- If you are the spouse or child of a Patient and you are making a claim for payments you made **out of your own resources** to a long stay facility on behalf of a Patient please fill in **Section A, Section B, Section C** where appropriate, **Section E, and Section F**, and **swear** this form on the last page.

***CLAIMS IN RESPECT OF DECEASED PERSONS***

- If you are making a claim where a **Grant of Representation** has issued to you please fill in **Section A, Section B, Section C** where appropriate, **Section E, and Section G**, and **swear** this form on the last page.
- If you are making a claim on behalf of the estate of a deceased person and you have **received a Certificate** entitling you to make a claim on behalf of that deceased person, please fill in **Section A, Section B, Section C** where appropriate, **Section E, and Section H**, and **swear** this form on the last page.
- If you are considering making a claim on behalf of a deceased person in whose estate **NO Grant of Representation** has been extracted please fill in the blue form '**Entitlement to Extract a Grant**' only and send it to Health Repayment Scheme, PO Box 330, Tralee, Co Kerry, Ireland. **PLEASE DO NOT FILL IN THIS CLAIM APPLICATION FORM YET** until you have received a Certificate entitling you to do so from the Scheme Administrator.

**PLEASE RETURN FORM AND ANY OTHER CORRESPONDENCE TO:  
HEALTH REPAYMENT SCHEME, PO BOX 330, TRALEE, CO. KERRY, IRELAND**



TO BE FILLED OUT FOR ALL PATIENTS

**SECTION A - PATIENT'S DETAILS**

Forename:

Middle name:

Surname:

Any other names used:

Address prior to admission

Date of birth  /  /  (dd/mm/yyyy) Date of Death  /  /  (dd/mm/yyyy)  
*(If applicable)*

Personal Public Service (PPS) Number or RSI Number (if patient had one)

Did patient hold a medical card (if known)  Yes  No

If Yes, please provide card number (if known)

If No, please fill in Section C below

**SECTION B - DETAILS OF LONG STAY FACILITY WHERE THE PATIENT RESIDED**

*Please list long stay facilities in date order, starting with most recent.*

*Please fill in the section as best you can. It will help the Scheme Administrator to connect the records in separate long stay facilities, to ensure your claim is complete.*

**Most recent/current location the Patient identified in section A above is/was resident in**

Name of long stay facility

Address of long stay facility

Year of Admission  Date of Admission (if known)  /  /  (dd/mm/yyyy)

Date or approximate date of Discharge (if known)  /  /  (dd/mm/yyyy)

**If patient identified in section A above resided in other long stay facilities please give details**

Name of long stay facility

Address of long stay facility

Year of Admission  Date of Admission (if known)  /  /  (dd/mm/yyyy)

Date or approximate date of Discharge (if known)  /  /  (dd/mm/yyyy)

Name of long stay facility

Address of long stay facility

Year of Admission  Date of Admission (if known)  /  /  (dd/mm/yyyy)

Date or approximate date of Discharge (if known)  /  /  (dd/mm/yyyy)



**SECTION C - INFORMATION ON THE PATIENT'S INCOME TO HELP DETERMINE IF THE PATIENT IS ELIGIBLE FOR REPAYMENT**

*If the person named in Section A had a medical card you do not need to complete this section. This section will assist the scheme administrator to process your claim quickly if you had no medical card.*

*Please tick as appropriate if information is known to you*

Patient's pension/allowance while in care

Non Contributory Old Age Pension

Disability Allowance

Invalidity Pension

Contributory Old Age Pension

Other pension/allowance  Please specify

Patient's Social Welfare pension/allowance Number (if known)

Were charges paid for the Patient's care based on other income in excess of the Patient's pension as listed above  Yes  No

If yes please give details of additional payments

**CLAIMS MADE ON BEHALF OF LIVING PATIENTS**

**SECTION D - APPLIES TO ANY LIVING PATIENT WHO IS HAVING THIS FORM PREPARED BY SOMEBODY ELSE ON THEIR BEHALF**

*Please see section one of the information sheet*

(i) Are you the person nominated in writing by the patient ? Yes

**If Yes, please attach written document signed by the patient**

(ii) Are you the appointed next friend ? Yes

**If Yes, please attach a certified copy of the Court Order**

(We will return this document to you when noted)

(iii) Has an enduring power of attorney been activated ? Yes

**If Yes, please attach a certified copy of the Certificate of Registration**

(We will return this document to you when noted)

(iv) Is the Patient a ward of court ? Yes

(v) Is the claim being made by HSE on behalf of the patient? Yes

**If Yes, specify grade of HSE person making the claim**

**SECTION E - IF THE CLAIM FORM IS BEING COMPLETED BY ANYBODY OTHER THAN A LIVING PATIENT PLEASE PROVIDE YOUR DETAILS**

Forename of person making the claim

Surname of person making the claim

Address of person making the claim

Telephone number of person making the claim

Personal Public Service (PPS) Number or RSI Number of person making the claim

Date of birth of person making the claim  /  /  (dd/mm/yyyy)

# HEALTH REPAYMENT SCHEME



## CLAIMS BY LIVING SPOUSES AND CHILDREN

### SECTION F - PAYMENTS MADE BY THE PATIENT'S SPOUSE AND/OR CHILDREN OUT OF THEIR OWN RESOURCES ON BEHALF OF THE PATIENT TO THE LONG STAY FACILITY

Are you the spouse of the patient?      Yes       No

If you are the **spouse of the Patient** and you are making a claim for **payments you made** to the long stay facility **out of your own resources** on the Patient's behalf please attach a **COPY OF A MARRIAGE CERTIFICATE PLUS PROOF OF PAYMENT (where available)** of amounts you paid to the long stay facility e.g. receipt from the HSE long stay facility.

Are you the child of the patient?      Yes       No

If you are the **child of the Patient** and you are making a claim for **payment you made** to the long stay facility **out of your own resources** on the patient's behalf please attach a **COPY OF A BIRTH CERTIFICATE (short form) PLUS PROOF OF PAYMENT (where available)** of amounts you paid to the long stay facility e.g. receipt from the HSE long stay facility.

If yes to either of the above questions please give details of additional payments (if known)

## CLAIMS IN RESPECT OF DECEASED PERSONS

### SECTION G-CLAIM MADE WHERE A GRANT OF REPRESENTATION HAS BEEN OBTAINED

Confirm you are the person who extracted the Grant of Representation in the estate      Yes       No

**If Yes, please attach original Grant of Representation or official copy obtained from the Probate Office, Dublin or the relevant District Probate Registry (We will return this document to you when noted)**

### SECTION H-CLAIM MADE WHERE A GRANT OF REPRESENTATION HAS NOT BEEN OBTAINED

Confirm you are the person who is certified to be entitled to extract the Grant of Representation in the estate  
Yes       No

**If No, please read the blue form 'Entitlement to Extract a Grant'**

When your claim is approved and calculated you will be offered the opportunity to donate some or all of your repayment to the Repayment Scheme (Donations) Fund.

The Repayment Scheme (Donations) Fund will be used by the HSE in addition to State allocated funds to improve public health services and quality of care for dependant older persons or persons with disabilities. Funds donated will be used in as far as is practicably possible for the purpose intended whether that purpose relates to a local long stay facility, a particular service or a general health service area.

I make this claim under the Health (Repayment Scheme) Act 2006. I do solemnly and sincerely declare that the information set out above is true and correct and I make this solemn declaration conscientiously believing the same to be true and by virtue of the Statutory Declarations Act, 1938. I understand that by accepting a payment under the scheme I will waive my right to sue for recoverable health charges and that I will be unable to make any further claim in respect of the relevant person referred to above under the scheme.

### IMPORTANT NOTICE

**Under Section 19 of the Health (Repayment Scheme) Act 2006 a person who knowingly gives false or misleading information in completing this form shall be guilty of an offence. The maximum penalty is a fine of €25,000 or imprisonment for a term not exceeding two years or both. In addition any payment or overpayment obtained through fraud or misrepresentation shall be repayable on demand. If you have only part or incomplete information or are unsure of some of the details e.g. dates, please provide the information as best you are able to do so. Any information given in good faith will not be considered under the terms of Section 19 of the Health (Repayment Scheme) Act 2006.**

**I authorise the Scheme Administrator and the HSE to access all relevant records and to make any necessary enquiries about the claim that it needs to process this application**

Declared before me on the      day of      200  
At      In the County/City of      and I know the deponent

Peace Commissioner/Practising Solicitor

Patient/Claimant