Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Application for **Assessment of Need** under Disability Act 2005

Notes on Filling Out This Application

1. Please fill out as many of the sections on this form as you can as only completed applications can be formally accepted. However, if there is a section about which you are unsure, make a note on the form and the Assessment Officer will help you.

2. In order for the application form to be considered complete, Part 1 of Section 10 must be signed and dated by the young person (if aged over 16 years), a parent or Legal Guardian. The signature confirms both the application details and consent under the Data Protection Act.

3. It would be very helpful if you were able to include, with the application, any reports that have been produced concerning the child or young person for whom you are making this application.

4. This application form will be held securely and for no longer than is necessary.

Please Complete Application Summary Detail: **Child's Name:** _____ **Age**: _____ **PPS Number:**_____	**HSE Date Received Stamp**
IT IS IMPORTANT THAT THE PPS NUMBER IS INCLUDED (If not known, it can be obtained from your local Department of Social & Family Affairs Office)	

Private & Confidential

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Health Service Executive

Application for **Assessment of Need** under Disability Act 2005

Please send completed Form To:	*For Official Use Only*	
Please see contact details for your local Assessment Officer on www.hse.ie	*Received*	
	Acknowledged	
	Other Action	
	IT Number	

PLEASE USE BLOCK CAPITALS AND BLACK INK WHEN FILLING IN THIS FORM

1. Details of the Person Making the Application					
First Name		**Family / Surname**			
Address					
Telephone Number		**Email Address**			
Relationship to person to be assessed					
Signed		**Date**			

2. Details of the Child / Young Person to be Assessed					
First Name		**Family / Surname**			
Address					
Date of Birth		**Male**		**Female**	

3. Details of Parent(s) or Legal Guardian(s)(If different from Section 1)			
First Name		**Family / Surname**	
Address			
Telephone Number			
Relationship to Child / Young Person			

First Name		**Family / Surname**	
Address			
Telephone Number			
Relationship to Child / Young Person			

4. What are the main concerns that you have about this child / young person?

5. Are there specific services that you feel are necessary to address these concerns?

6.	Have you been advised by a Health or Education Professional to apply for this assessment of need?

Yes ☐ **No** ☐

7.	If yes, please state their name, profession and contact details if known.		
Name		**Profession**	
Address			
Telephone Number			

8.	Please give details of your GP.
Name	
Address	
Telephone Number	

9. Is this child / young person receiving, or has he / she ever received services from any of the professionals listed below?

(If you have access to any existing reports, please include them with your application form.
Please see Notes on Filling Out This Application – Number 3)

Service being received	***Name of professional***	***Are there any existing reports?***	***Contact details for the service*** *(Address and phone number if possible)*
Public Health Nurse			
Paediatrician			
Consultant Psychiatrist			
Psychologist			
Speech & Language Therapist			
Physiotherapist			
Occupational Therapist			
Social Worker			
Orthopaedics			
Audiologist			
Ophthalmologist			
Pre School / School			
Orthotist			
Dietician			
Others (Please specify)			
Voluntary Groups (Please specify)			

Do you have a Medical Card? If so please give the number:				
Do you receive Domiciliary Care Allowance?	**YES**		**NO**	

10. Consent - To be Completed by Parent or Legal Guardian. Or by the young person if aged 16 years or over.

Child / Young Person's Name in BLOCK CAPITALS	
Child / Young Person's Address in BLOCK CAPITALS	
Date of Birth	

PART 1

I consent to allow access to all files and reports (including any information held on either the National Intellectual Disability Database or the National Physical and Sensory Disability Database) that exist within any of the agencies listed, that the Assessment Officer may consider necessary for the purposes of assessment and subsequent service provision.

- **The Health Service Executive (HSE);**
- **HSE contracted service providers;**
- **Education service providers;**
- **The National Council for Special Education;**
- **The National Educational Psychological Service.**

I also consent to the sharing of this information with those health and education professionals involved in the assessment of need and subsequent provision of services.

Signed by Young Person (16 years+)	
Signed by Parent or Legal Guardian	
Relationship to the Child	
Date	

PART 2

Where there is a need for referral to a statutory service provider other than the HSE or Education Service, (Local Authority Housing Department etc), I consent to the sharing of assessment findings and reports with such service providers.

Signed by Young Person (16 years+)	
Signed by Parent or Legal Guardian	
Relationship to the Child	
Date	

NB: If you do not sign Consent - Part 2 (above) reports will not be shared with other service providers and any such referral will only be made with your express permission.