REPUBLIC OF CYPRUS
DEPUTY MINISTRY OF SOCIAL WELFARE

DEPARTMENT FOR SOCIAL INCLUSION OF PERSONS WITH DISABILITIES
1430 NICOSIA

APPLICATION FOR CARE ALLOWANCE FOR PARAPLEGICS OR QUADRIPLEGICS

(please read the attached information before proceeding with the completion of the form)

A. APPLICANT'S DETAILS:

1. Name:……..	**2.** Surname:……
3. Identification No:…….……..	**4.** Social Insurance No:……..
5. Date of Birth:…….……..	**6.** Citizenship:…… • *(Citizens of the EU should provide certificates proving their permanent residence in the Republic of Cyprus for 12 consecutive months* • *Persons with recognized refugee status or with subsidiary protection status should provide a letter from the Asylum Service or a Residence Permit in force issued by the Civil Registry and Migration Department stating the recognized refugee status or subsidiary protection status)*
7. Address:…….....	**8.** Municipality/Region:……
9. Postal Code:…….....	**10.** Residence tel. number:……..
11. Mobile tel.number:……	**12.** Work tel. number:…….
13. Accomodation in Nursing Home/ Rehabilitation Center: Yes / No If yes applies please fill out no **14**	**14.**Nursing Home/ Rehabilitation Center's Details: Name:…….. Address:……. Tel no:…… Manager's Name:…….
15. Family Status : ☐ Married ☐ Single ☐ Widowed ☐ Divorced	**16**. Profession:……..
17. Date of disability onset:……..:……..	
18. Short description of disability: …… ……..	

B. PARENT / GUARDIAN / ALTERNATIVE PERSON FOR COMMUNICATING DETAILS: (Please complete this section only if the applicant is under the age of 18 or has a guardian / trustee or if the applicant for whatever reason cannot provide the needed information)

1. Name:……..	**2.** Surname:……
3. Identification No:…….……..	**4.** Profession:…….……..
5. Relationship (relative / other relationship) with the applicant :	

C. EXISTING CARE BENEFITS:

Care Benefits already acquired from Goverment Sources:	**Mark with √ the benefits you are receiving:**	**Monthly Amount €**
Care Allowance for Paraplegics (DSID)		
Care Allowance for Quadriplegics(DSID)		
Home Care Service (SWS)		
Day Care Service (SWS)		
Residential Care Service (SWS)		

Note: DSID= Department for Social Inclusion of Persons with Disabilities, SWS= Social Welfare Services

D. REQUESTED CARE BENEFIT:

Care needs according to type and extent of Disability	**Mark with √ the benefits you are requesting:**
Care Allowance for Paraplegics	
Enhanced Care Allowance for Paraplegics	
Care Allowance for Quadriplegics	
Enhanced Care Allowance for Quadriplegics	

Note: In case you are applying for the enhanced care for paraplegics or quadriplegics, it is necessary for your Attending Physician to fill in the form "Special Justification of Enhanced Care Needs" **(page 4)** of this application. If it concerns a new applicant, all the necessary forms required by submitting the application must be submitted.

…… ……

Date Applicant's Signature

E. Information

Applicants may be called for a disability assessment and certification, at the Disability Assessment Center of the Department and have to complete the Declaration Form stating if they wish to be assessed only for their disability or for both their disability and functioning.

'Assessment of disability "means an assessment carried out by two or three doctors with specialties directly intertwined with the disabilities the person may be facing. The purpose of the disability assessment is to identify, describe and document the existence and extent of disability and to provide advise whether the person's disability fulfills the criteria and requirements required by the legislations and schemes of the social benefits and services offered by the state.

The assessment of functioning is optional, and takes place only if the applicant desires so, and declares it on the Declaration Form. The "assessment of functioning" is carried out by two or three rehabilitation professionals (physiotherapists, occupational therapists, speech therapists, psychologists), again depending on the type of disability of the individual. "Functioning" means the capacity and ability of the individual to be active and participate in all areas of life and the purpose of the assessment is to identify, describe and document the constraints faced by the person in everyday life and the necessary support and interventions needed to reduce these limitations. These interventions do not necessarily correspond to economic benefits. They may correspond to different types of treatments or services needed by the person or the use of specific technical tools / wheelchairs / devices that are directly and specifically tailored to the needs of the individual. Also, these interventions may correspond to education, training and work. Through the assessment of functioning the person with disability is offered a multidisciplinary assessment of the needs and capabilities and suggestions are provided on how to increase quality of life and how to enhance active participation and social inclusion.

In cases were the applicant is staying in a Nursing Home or Rehabilitation Center apart from the details of the Center, the details of a relative of the applicant is required.

For the assessment of the application the following documents **need to be attached:**

- **Recent original reference from personal doctor (on the specified document of the Department):**
- **In the case that you already have presented an original reference form during the last year and your condition has not changed, then you don't need to provide a new reference form from a doctor.**
- **Clinical or Lab Assessments (if you have)**
- **Discharge forms from Medical Institutions (if you have)**
- **Original Declaration Form (on the specified form of the Department)**

- **Copy of Birth Certificate**
- **Copy of Identification Certificate**
- **For citizens of the EU documents need to be attached that prove their permanent residence in the Republic of Cyprus for 12 consecutive months**
- **For persons with recognized refugee status or with subsidiary protection status should provide a letter from the Asylum Service or a Residence Permit in force issued by the Civil Registry and Migration Department stating the recognized refugee status or subsidiary protection status**
- **For persons staying in a Nursing Home/ Rehabilitation Center a special document must be submitted by a relative that he/she is aware that the application for the allowance is submitted**

IN CASE YOU ARE APPLYING FOR THE ENHANCE CARE ALLOWANCE FOR PARAPLEGICS OR QUADRIPLEGICS THE FOLLOWING DOCUMENTS MUST BE SUBMITTED:

- **Special Justification Of The Need For Enhanced Care By A Doctor (Page 4)**
- **In case you are staying in a Nursing Home / Rehabilitation Center please provide a detailed report from the Center with detailed description of the care services it provides.**
- **Recent original reference from rehabilitation professional** (if you have one, on the specified form of the Department)

Complete applications, accompanied by all other documentation can :

Be delivered in person at:	**Department for Social Inclusion of Persons with Disabilities, 67, Archbishop Makarios III Avenue, 2220 Latsia, Nicosia Or Disability Assessment Center in Limassol 11 Apostolou Andrea, Hyper Tower, Store 1, 4007 Mesa Geitonia, Limassol Or Disability Assessment Center in Larnaka 25 Acropoleos & Chanion, 7000 Meneou, Larnaka**
Be sent by post at:	**Department for Social Inclusion of Persons with Disabilities,1430 Nicosia or P.O. Box 12833, P.C. 2253 Latsia Or Disability Assessment Center in Limassol, P.O. Box 70801, 3803 Limassol Or Disability Assessment Center in Larnaka, P.O. Box 43241, 7565 Kiti, Larnaka**

SPECIAL JUSTIFICATION OF THE NEED FOR ENHANCED CARE BY A DOCTOR:

This form is only completed in case of application for provision of enhanced care and only by the attending physician. It is noted that, if it concerns a new applicant, they should additionally provide all the other required forms, see page 3)

Applicant's Details:

Name:…… Identification No:……..

Please answer all of the following questions regarding this particular applicant.

	Circle the appropriate answer
Is the applicant on continuous or periodic invasive mechanical ventilation? (If yes, attach a certificate from a State Hospital for the type of ventilator)	**YES/ NO**
Please provide a detailed explanation of the type, necessity and frequency of ventilator use:	
Does the applicant have a permanent tracheotomy?	**YES / NO**
Is the applicant mechanically supported for the function of defecation and/or urination?	**YES/ NO**
Please provide a detailed explanation of the type, necessity and frequency of mechanical assistance with defecation and/or urination:	
Other reasons necessitating enhanced care of the applicant:	

Date: _____

Name of Doctor: _____

Tel no: _____

Signature and Stamp of Doctor