Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Medical Card / GP Visit Card Application Form - MC1

Date Received _____

Please read the back page help sheet carefully before you complete the form. Please use block capitals

Part 1A Applicant's Details

First Name(s) _____ Surname(s) _____

House Number / Name _____ Date of Birth ☐☐☐☐☐☐☐☐

Address line 1 _____

Address line 2 _____ Contact Phone Number _____

Address line 3 _____

Male ☐ Female ☐

Address line 4 _____

Town / Postal Area _____

County _____ P.P.S.N. (RSI) No. ☐☐☐☐☐☐☐☐☐

Do you live alone? Yes ☐ No ☐ If No, with whom do you live? _____

Your Birth Surname _____ Your Mother's Birth Surname _____

E-mail Address: _____

Are You? (Please tick ✓ as appropriate) Married / Cohabiting ☐ Single ☐ Widowed ☐ Separated / Divorced ☐

Do you hold or have you ever held a Medical Card? Yes ☐ No ☐

If 'Yes' please state: Who was the Issuing Authority? _____ Medical Card Number _____

Part 1B For Completion by persons aged 16-25 years

Are you financially dependant on your parents? Yes ☐ No ☐

If you answer 'No' please complete parts 1a, 2, 3, 4, 5 and 6a of this form

If you answer 'Yes' please complete all parts of this form.

Parent(s) medical card number _____

Expiry Date _____

Where was it issued from? _____

Name of School / College being attended _____

Expected completion date of course _____

School / College Stamp

Part 2 Details of your Spouse / Partner & any dependants

What is your Spouse's / Partner's Birth Surname_____ What is your Spouse's / Partner's Mother's Birth Surname?_____

	First Name(s)	Surname(s)	Date of Birth	P.P.S. Number (Formally RSI Number)	Sex M / F	Relationship to you	Does this person have their own Income and / or an Educational Maintenance Grant (Please specify)
Spouse / Partner							
Dependants Under 16 years							
Dependants Over 16 years							

Child Benefit Claim Number: _____

Part 3 Details of Income - All Sections Must Be Completed

Please attach documentary evidence of Incomes.

A. What is your weekly gross income and that of your spouse / partner from the following sources?

Source	Yourself €	Type of Payment	Spouse / Partner €	Type of Payment
Social Welfare Payment(s)				
Health Service Executive Payment(s)				
Social Security Payments (from a non E.U. State)				
Social Security Payments (from an E.U. State)				

B. What is your weekly gross income and that of your spouse / partner from the following sources?

Source	Yourself €	Spouse / Partner €
Wages		
Self Employment		
Sick Pay / Income Protection Schemes		
Occupational Pension(s)		
Maintenance Payments		
FAS Training Allowance		
Any other source(s) PLEASE SPECIFY		

C. Have you or your spouse / partner investments in stocks, shares, or deposits with Banks / Building Societies or other Financial Institutions? Yes ☐ No ☐ If yes please provide details and evidence of Investments

Amount(s) Invested €	Where Invested	Income Earned Per Year €

D. Do you or your spouse / partner own any property (including land not personally used) other than the house you occupy? Yes ☐ No ☐ If yes please give details and the annual Income received from the property.

E. Back To "Employment / Education" Schemes

	Type of Scheme	Date of Commencement	Expected Finishing Date
Self			
Spouse / Partner			

Part 4 Detail of Outgoings - All Sections Must Be Completed

Please attach documentary evidence of outgoings.

A. Housing

	Amount €	Weekly / Monthly €	Payable To
Rent			
Mortgage			

B. Travel Costs To Work

	Place of Employment	Type of Transport Used	Weekly Cost €	Total Kilometres (Return Journey)
Yourself				
Spouse / Partner				

C. Loans e.g. Banks / Credit Union, Hire Purchase, Lease

	Purpose of Loan	Expiry Date of Loan	Weekly Repayment €
Loan 1			
Loan 2			
Loan 3			

D. Maintenance Payments To Another Person

To whom _____

Address _____

Amount € _____ per week

E. Please provide details and evidence of any other issues which you wish to be considered. (e.g. GP fees / prescribed drug / medicines / appliances, hospital charges and travel / accommodation costs associated with attending clinics / hospitals.)

_____

_____

_____

F. Are any of your medical costs covered by Private Medical Insurance or Employment / Benevolent Fund Assisted Schemes? Yes ☐ No ☐

If 'Yes' please provide details: _____

_____

_____

G. Are there any other circumstances or issues not included above which you wish to have considered (e.g. money management issues or child care costs)?

_____

_____

_____

Part 5 Declaration

I hereby apply for a Medical Card / GP Visit Card for myself and / my dependants as listed.
I have read the note below and I declare that the information given by me on this form is to the best of my knowledge and belief correct.

I agree to immediately report any changes which may affect my eligibility for health services and that of my dependants.
I agree that the Health Service Executive and its agents may make any inquiries that they think fit for the purpose of considering my eligibility and that of my dependants.

Signature of Applicant: _____

Date: _____

NOTE

(a) A person who knowingly makes a false statement, conceals any material fact or produces a false document in support of a claim is liable to a fine or to imprisonment for up to three months or both a fine and imprisonment under Section 75 Health Act 1970 as amended by the Health (Amendment) Act 2005.

(b) A person who fails to notify the Health Service Executive of a change in circumstances which would affect their eligibility for a Medical Card / GP Visit Card is liable to a fine under Section 49 of Health Act 1970 as amended by the Health (Amendment) Act 2005.

Help Sheet for Completion of ‘Medical Card / GP Visit Card’ Application Form (MC1)

Please read this help sheet carefully before completing your application.
Failure to answer all appropriate sections of the form and / or to include documentary evidence may delay the processing of your application.

All applicants other than those who are aged 70 years or over should complete this form (MC1).
Applicants who are aged 70 years or over should complete form MC2.

1. The following is a list of the items for which documentary evidence is required:

- Personal Public Service Number(s) (formerly known as RSI numbers) for yourself, spouse / partner and all dependants listed in part 2 of the form.
- All incomes listed in sections A,B,C and D of part 3 of the form.
- All outgoings listed in sections A,B,C,D,E and G of part 4 of the form.
- Commencement and expected completion dates of ‘Back to Employment / Education’ Schemes.

2. Part 5 should be read and signed when the form has been fully completed.

3. Part 6a should be completed and signed by the client. Part 6b should be completed and signed by the doctor of choice.

CHECKLIST - Have You:

- Completed all relevant parts and signed the form?
- Provided proof of P.P.S. No. (formally R.S.I. No.) for yourself, your wife, husband or partner and any dependants?
- Provided proof of all incomes and assets declared in part 3?
- Provided proof of all outgoings including loans, rents, mortgages, and other costs you declared in part 4?
- Signed part 5?
- Completed and signed part 6a
- Arranged for your doctor of choice to complete and sign part 6b

If you need further help with the completion of your application form please call the local Health Office / Centre. Completed forms should be sent to your local Health Office / Centre

Part 6: To Be Completed By Client & Doctor Of Choice

Part 6a - To be completed by Client

Name

Address

I have chosen Dr.

of

to be my General Practitioner for the provision of General Medical Services.

I reside ____ miles from his/her main centre of practice

Client's Signature Date

Part 6b - To be completed by Doctor

ACCEPTANCE OF ELIGIBLE PERSON

I agree to provide General Medical Services (GMS) to the above named (and/or dependants), subject to elegibility, in accordance with my agreement with the HSE for the provision of services under Section 58 of the Health Act 1970 as amended by the Health (Amendment) Act 2005.

Signed (General Practitioner)

GMS Registered No.

Date

Please place official GMS stamp here

For Official Use Only

Distance Code