States of Guernsey
Social Security

Edward T. Wheadon House
Le Truchot, St Peter Port
Guernsey, GY1 3WH
+44 (0) 1481 221000
socialsecurity@gov.gg
www.gov.gg

Severe Disability Benefit

Section 2 – How your medical condition affects you

If you wish to claim, please complete this form and take it to your treating GP or specialist doctor and ask them to complete the medical declaration.

Please read the guidance notes before filling in the claim forms.

Section 2 – Personal Details

Please fill in these details so that we can keep your papers together.

Remember, if you are filling in this form for someone else, tell us about them, not yourself.

Title	
Last name	
First name(s)	
Date of birth	/ /
Social Security number (if known)	
Usual address	
	Postcode Telephone
	Email

Section 2 – Mobility

Describe your mobility in your own words.

Please tell us if this is the same at night or if your needs are different between day and night.

Day and night are the same ☐ **Day and night are different** ☐

If day and night are different, how do the needs differ?

If you need aids or certain adaptations to help with your mobility, please describe them in the table below:

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with your mobility and how long can this help sometimes take?

Section 2 – Washing/Showering/Bathing

Describe your washing needs in your own words:

If you need aids or certain adaptations to help with your washing/showering/bathing, please describe them in the table below.

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with washing and how long can this help sometimes take?

Section 2 – Toilet Needs

Describe your toilet needs in your own words:

If you need aids or certain adaptations to help with your toilet needs, please describe them in the table below.

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with your toilet needs and how long can this help sometimes take? Describe if your needs are different between the day and night.

Section 2 - Dressing

Describe any difficulties you may have getting dressed:

If you need aids or certain adaptations to help with getting dressed, please describe them in the table below.

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with getting dressed and how long can this help sometimes take?

Section 2 – Meal Times

Describe any difficulties you may have with eating and drinking:

If you need aids or certain adaptations to help with eating and drinking, please describe them in the table below.

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with eating and drinking and how long can this help sometimes take?

Section 2 – Communicating

Describe the problems you may have and help you need communicating with other people:

If you need aids or certain adaptations to help with communication, please describe them in the table below.

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with communicating and how long can this help sometimes take?

Section 2 – Mental Health

Describe any mental health issues you may have:

How often do you suffer from mental health problems and what sort of help do you need when you have these problems?

Section 2 – Risks

If risks apply, what are they? Do they arise because of your physical or mental health condition? How often and for how long do you require supervision in order to keep safe from dangerous situations?

Section 2 – Medical Treatment

Describe the medical treatment that you receive at the moment:

If you need aids or certain adaptations to help with your medical treatment, pleased describe them in the table below.

Aids and adaptations	How does this help you?	What difficulties do you have using this aid or adaptation?

How often do you need help with your medical treatment and how long can this help sometimes take?

Section 2 – A Typical Day and Additional Information

We know that some people have good days and bad days. It will help us if you can tell us about an average day. Tell us about the sort of things you normally do and how you pass the time. Please include details about the care you receive from your family, friends or any professional carer.

You can also use this page to tell us anything about your medical condition that you have not already put elsewhere on the form that might help us to understand your care needs.

Section 2 – Extra Questions About Children

Is your child under school leaving age? (as defined in the guidance notes) **Yes** ☐ **No** ☐

What medical condition does your child have?

How does this condition impact on their daily life?

How often does your child need extra help or supervision? How long does he/she need this?

Please tell us if this is the same at night or if their needs are different between day and night.

Day and night are the same ☐ **Day and night are different** ☐

If day and night are different, how do the needs differ?

For how long can your child be safely left without supervision?

Is your child ever allowed out of the house alone? **Yes** ☐ **No** ☐

Section 2 – Extra Questions About Children (continued)

If you answered Yes to the previous question, please give details of how this is managed or supervised.

If you answered No to the previous question, what danger would your child be in if they were left unsupervised or allowed out for long periods?

Is there anything else about your child's behaviour that impacts on their and your daily life that is not mentioned anywhere else on this form?

Does your child attend school?

Yes ☐ **No** ☐ **If yes, which school?**

If no, please tell us why your child does not attend school.

What special needs, if any, does your child have at school?

How does your child travel to and from school?

Who provides the constant supervision for your child?

At home:	**At school:**

Section 2 – Your Declaration **Please read the section below and sign in the space provided**

1. To the best of my knowledge and belief the information given on this form is true and complete;
2. I believe that I need frequent attention and/or continual supervision – see guidance notes (SDB3);
3. My income and that of my spouse or any other person with whom I am living (as if married) does not exceed £113,400 a year; income and savings include interest from investments, dividends, gratuities, directors or other fees, occupational pensions and social insurance benefits from any country;
4. I authorise the Director of Revenue Services to disclose my annual income which is being used as the basis of the assessment of income tax for the relevant year of charge;
5. I authorise my doctor to complete the sections on pages 11 and 12 of this form and may also provide additional information in connection with the processing of this claim.
6. I authorise any medical practitioner, health and social care professional or head teacher (in the case of a child) to provide information relevant to my claim.

Warning – To give false information may result in prosecution

Sign here		Date	/ /
Full name			

If you have completed this form for someone else, please provide your details in the space below.

Your name	
Your address	
	Postcode Telephone number
	Email address
Relationship with the applicant	

How we collect and use information

The Committee *for* Employment and Social Security will process any personal data which you provide, via this form, in accordance with the Data Protection (Bailiwick of Guernsey) Law, 2017. Further information about how your personal data is processed can be found at www.gov.gg/dp or alternatively at you may call 01481 221000 and request a paper copy.

What happens next?

Please take this form to your treating GP or Specialist. Once they have considered the information they should read and complete the declaration on the next page. This form should be returned to us as soon as possible.

Please note that this form (Section 2) needs to be returned to Social Security within 3 months from the date we received Section 1.

If the form is received at a later date, you may lose some of the benefit.

Section 2 – Medical Practitioner's Declaration

This section should be completed by your treating GP or specialist.

Please provide a clinical diagnosis for the medical condition this person is suffering from. If the person is suffering from more than one illness or disability, please list them in the order that they influence the person's need for attention/supervision, ranking the most severe first.

Please provide any additional information relevant to this claim.

Is this diagnosis known to:

The person **Yes** ☐ **No** ☐ **The person's family** **Yes** ☐ **No** ☐

When was the last time you examined this person? / /

How many times have you examined this person in the last 2 years?

Please enclose details of any medication currently prescribed.

When did the person's need for the current level of care first arise? / /

Is the level of care this person needs likely to **Increase** ☐ **Decrease** ☐ **Stay the same** ☐

Section 2 – Medical Practitioner's Declaration

Is the person named on page 1 of this form suffering from a terminal illness? **Yes** ☐ **No** ☐

Please provide an approximate prognosis in weeks or months Weeks/months

Declaration

By signing the declaration below you are agreeing that, to the best of your knowledge and belief, your patient fulfils the criteria for severe disability benefit in that they require:-

- Frequent attention throughout the day in connection with their bodily functions; or
- Continual supervision throughout the day in order to avoid substantial damage to themselves or others; or
- Prolonged or repeated attention during the night in connection with their bodily functions*; or
- Another person to be awake for a prolonged period or at frequent intervals during the night to watch over them in order to avoid substantial danger to themselves or others.

***Please note:** Bodily functions include things like breathing, dressing, undressing, eating, drinking, going to the toilet, taking a bath or shower, getting into or out of bed, sitting, sleeping, hearing, seeing and communication with other people.

They **do not** include daily living activities such as cooking, shopping or doing the housework.

If severe disability benefit is awarded, when, in your professional opinion, should the level of attention/supervision that the person needs, be reviewed?

Review by / / **OR** **No review needed** ☐

I declare that to the best of my knowledge and belief the information I have provided above is true and complete.

Sign here **Date** / /

Practitioner's name

Practice stamp