An Roinn Gnóthaí Fostaíochta agus Coimirce Sóisialaí
Department of Employment Affairs and Social Protection

COMMUNITY EMPLOYMENT ELIGIBILITY FORM

VACANCY NUMBER: ______________________

To be completed and submitted to your local Community Development Officer in the Department for consideration before an applicant can be approved to participate on a Community Employment scheme

PART 1: APPLICANT WISHING TO PARTICIPATE ON A COMMUNITY EMPLOYMENT PROGRAMME

Applicant Name: (BLOCK CAPITALS): ____ Male ☐ Female ☐

PPSN: ______________________ DEASP Protection Payment Y ☐ N ☐ If 'Y' Type of payment______________________

Contact Phone No:______________________________________ Date of Birth:____

Are you availing of supported childcare places (CEC) Y ☐ N ☐ If 'Y' Please state the number of places in Pre-school ☐ After school ☐

Address: ____

I am aware that if I am attending JobPath that the funding of my placement is subject to continued participation with the JobPath provider ☐

I undertake to advise my employer of any change in my circumstance that may impact on my payment. ☐

DATA PROTECTION STATEMENT

The Department of Employment Affairs and Social Protection administers Ireland's social protection system. Customers are required to provide personal data to determine eligibility for relevant payments/benefits. Personal data may be exchanged with other Government Departments/Agencies where provided for by law. Our data policy is available at www.welfare.ie/dataprotection or in hard copy.

Applicant Signature: ____ Date:____________________________________

PART 2: TO BE COMPLETED BY COMMUNITY EMPLOYMENT SPONSORING COMPANY

Sponsoring Company Name: ______________________________________DEASP Reference No:____________________________

Postal Address: ____

Job Title: ______________________________________ Job Description____

Proposed Start Date: ______________________________ Proposed End Date____

Sponsor/Company Director Name (BLOCK CAPITALS): ____

Sponsor/Company Director Signature: ____ Date:__________________________

PART 3: TO BE COMPLETED BY DEASP COMMUNITY SERVICES

ELIGIBLE ☐ NOT ELIGIBLE ☐ (if the applicant is not eligible, please do not complete rate of pay information)

JOBPATH: YES ☐ NO ☐

PARTICIPANTS START DATE: ____________________________ FINISH DATE: ________________________________

Rate of Pay	€ ________	
CE Allowance	€ 22.50	
Island Allowance	€ ________	(if applicable)
Living Alone Allowance	€ ________	(if applicable)
Free Fuel	€ ________	(if applicable)

DEASP
Community Services Stamp

Does the payment above include a payment in respect of:
Adult Dependant Yes/No _______
Number full rate children _______ Number half rate children________

Signed: __________________________ **Date**: __________________
Higher Executive Officer

Contact Phone Number ____

Explanations and terms used in this form are intended as a guide only and are not a legal interpretation.

DSP CE Drugs Rehabilitation Place
Referral Form.
(Substance Misuse)

This form is to be completed by the appropriate Referral Practitioner as part of the DSP referral procedures to support an application for a CE Drug Rehabilitation Place.

CE Drugs rehabilitation places are available only to service users who are in drugs rehabilitation and referred to a place; this is defined as individuals attending either a HSE relevant addiction service or other relevant statutory, community based or voluntary drugs support service within the last year.

The local referral practitioner (Key Worker, Case Manager, Counsellor, GP, Treatment Centre Practitioner; Health Service Practitioner etc) identifies through the course of assessment and care planning with the Service User that a CE Scheme is an appropriate intervention to support rehabilitation and progression. Applicants referred to CE need to be stable and show the necessary commitment and ability to cope with the daily routine of programme participation.

For further information, please refer to the "DSP Guidelines on Referral for a CE Drugs Rehabilitation Place" (CE DRP RF 2)

Referral Details

Name of Service User: ____

Address: ____

DOB: ____

PPS Number: ____

Contact Number: Home: __________________ Mobile: ________________________________

Referral Agency Details

Name of Referral Practitioner : ____

Contact Address ____

Phone Number ____

Position: Key/Case Worker ☐ Case Manager ☐ GP ☐ Counsellor ☐ Treatment Centre worker ☐;

Health Service worker ☐ Other☐

If other, please specify ____ _________

Please provide details of any other Agency involved in supporting the Service User's Care Plan (use an additional sheet if necessary)

Contact details: ____

List any additional supports provided: ____

Does the Service User have any special needs? Yes ☐ No ☐

If yes, please specify ____

Please list any additional information that might be relevant for this application for a CE drugs rehabilitation place?

____

CE Scheme Details

Please list details of the CE Scheme that the applicant is being referred to:

CE Scheme Name: ____

Address: ____

CE Supervisor's Name: ____

CE Rehabilitation CE Scheme ☐ Standard CE Scheme ☐

Signed____

Date____

Please ensure the Service User completes the attached Information Release Consent Form.

Please forward this CE Referral Form and copy of the Information Release Consent Form to the CE Scheme.

Please provide a copy of the completed CE Referral Form plus Information Release Consent Form to the Service User following the decision to proceed with the CE application.

Please ensure that a completed copy of the DSP CE referral documentation (CE Referral Form plus Information Release Consent Form) is kept on file as part of the Service User's care and case management plan.