Ref:

# APPLICATION FORM
# SOCIAL DEPRIVATION SUPPORT ALLOWANCE

**(For the purpose of this application, a GMS patient is a holder of a Medical Card and excludes DVC holders and the Principal centre of practice is located in an urban area as per the CSO definition of Urban being a town with a population of 1,500 or more).**

**Practice Name**

**Principle Centre of Practice Address**

**Secondary Practice Premises Address**

## Nominated GP

(Each Practice should nominate one GP under whose GMS number the allowance will be payable)

| Nominated GP Name | GP GMS Number | Medical Council Number |
|---|---|---|
| | | |

**Practice Profile:**

**GMS GPs:**

(List all GMS GPs in the Practice including nominated GP and any flexible shared contract arrangement)

| NAME | GMS Number | Medical Council Number |
|---|---|---|
| | | |
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| | | |
| | | |

**Total Number of FTE GPs in Practice:**

(include all GPs, assistant, part time, flexible shared arrangements and GMS or non-GMS-
A half day is classed as one session, with full time being 9+ sessions. This does not include GP Registrars)

**Total Combined GMS list size for all GPs in the practice**

(Please note this should be GMS patients only and should not include Doctor Visit Card patients):

**Total number of patients living in extremely disadvantaged, very disadvantaged areas or disadvantaged areas using Pobal Deprivation Index maps** (See Guide to mapping patients):

**I confirm that my practice** (Place X as appropriate):

Is based in an urban area as per the CSO definition of urban (town of 1,500 or more) ☐

Is not in receipt of a Rural Practice Support Framework allowance ☐

Has a combined list size of over 350 GMS patients
*(Note: this does not include DVC patients)* ☐

Has over 200 GMS patients **(not including DVC patients or patients in long-term care / nursing home facilities)** living in extremely disadvantaged, very disadvantaged or disadvantaged areas *(Using Pobal Deprivation Index Maps)* ☐

Has made only one overall application for the Social Deprivation Support Allowance ☐

**I declare that the information I have given as part of this application is correct to the best of my knowledge. I agree to tell the HSE immediately about any changes that may affect my application. I agree that the HSE, when assessing eligibility, may use other sources to confirm the information I have given.**

**I can confirm that the HSE may deal directly with me as the nominated GP on all aspects of the application. I can confirm that I will provide vouched records of expenditure for year-end 2020 to the HSE by the end of January 2021.**

Medical Practitioners
Office Stamp

______________________ ______________________

**Nominated GP Signature** **Nominated GP**
**(**Print Name**)**

Date: ________________

**Applications will only be accepted by e-mail to** urban.deprivation@hse.ie

**For official HSE use only:**

**Rank Number :** ☐

**Amount Due : €** ☐

**Validated by:** ____________________________ **Date :** _________________
National Contracts Office Official

**Authorised by :** __________________________ **Date :** _________________
Geraldine Crowley, AND Primary Care Strategy & Planning