Application to the Remembrance Fund
(Scheme of Acknowledgement, Remembrance and Assistance for Victims in this Jurisdiction of the Conflict in Northern Ireland)

The Scheme is enclosed and outlines the categories and criteria under which applications will be considered (see in particular section 9). Please read the Scheme and attached Guidelines carefully.

For applications for assistance under sections 9 (a), 9 (b)(i), 9 (b)(iii) and 9 (b)(iv) there may be more than one person entitled to apply. It is the responsibility of the lead applicant to ensure that the details of all such persons are included in the application.

Completed application forms should be returned to:

Secretary
Remembrance Commission
1A Lower Grand Canal Street
Dublin 2

The final date for receipt of applications under sections 9 (a) and 9 (b) is 1 September, 2006. The final date for receipt of applications under section 9 (c) is 1 November, 2006.

All applicants are strongly encouraged to submit their applications as soon as possible in order to ensure that they can be processed in good time.

It is the intention that the administration of the Scheme will be informal and applications will be processed as quickly and as simply as possible. However, the Commission may require information or documentation additional to that requested in this form in order to process an application.

Please complete the necessary form/s in **BLOCK LETTERS** except where requested to do otherwise.

Form RF1

PERSONAL DETAILS
To be completed by all applicants

Details should be supplied for all applicants.

Name of Lead Applicant: ____

Sex (M/F) ____________________ **Marital Status:** _______________________
single/married/widowed/other (specify)

Current address of lead applicant ______________________________________

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Contact telephone numbers

Daytime _____________________________ **Other** _________________________

Date of birth (DD/MM/YY) ____/____/__________

Relationship to Victim (if applicable) _____________________________________

Please advise how you heard of Scheme __________________________________
(Word of mouth, radio, newspaper, etc.)

Other Persons Associated with Application

Person 2 Name: ____

Sex (M/F) ________________________

Address of person 2 (if different from address of lead applicant): _____________

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Contact telephone numbers (if different from those of lead applicant):

Daytime _____________________________ **Other** _________________________

Date of birth (DD/MM/YY) ____/____/__________

Relationship to Victim (if applicable) _____________________________________

Relationship to lead applicant ____

Person 3 Name: ____

Sex (M/F) ___________________

Address of person 3 (if different from address of lead applicant): ___________

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Contact telephone numbers (if different from those of lead applicant):

Daytime ________________________ **Other** _____________________

Date of birth (DD/MM/YY) ____/____/_________

Relationship to Victim (if applicable) _______________________________

Relationship to lead applicant ___________________________________

Person 4 Name: ____

Sex (M/F) _______________

Address of person 4 (if different from address of lead applicant): ___________

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Contact telephone numbers (if different from those of lead applicant):

Daytime ________________________ **Other** _____________________

Date of birth (DD/MM/YY) ____/____/_________

Relationship to Victim (if applicable) _______________________________

Relationship to lead applicant ___________________________________

If other persons are entitled to apply, please provide details as above on a separate sheet. If there are other persons who are entitled to apply and do not wish to do so, please forward written conformation from them stating same.

Form RF2

APPLICATION FOR ACKNOWLEDGEMENT PAYMENT UNDER SECTION 9 (a)

Name of victim ____

Sex of victim (M/F) ________ **Marital Status** (victim) ________________________
single/married/widowed/co-habiting/other (specify)

Address where victim resided at time of death _____________________________

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Date of incident (DD/MM/YY) _____/_____/__________

Description and location of incident in which fatal injury was sustained

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Was the incident reported to a relevant authority? Yes / No ________________

If yes, what relevant authority and when? ___________________________________

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If victim's fatal injury was sustained outside the State, please state

(i) **length of time victim was then resident in the State** ________________

(ii) **period(s) of residence in the State** ________________________________

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(iii) **address where the victim was resident in the State at the time of fatal injury**

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Any additional information or documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge. I give my permission to seek external confirmation or clarification of the information provided.

Signature ______________________________

Date _______________________________

Form RF3

APPLICATION FOR ECONOMIC HARDSHIP PAYMENT UNDER SECTION 9 (b) (i) (surviving souse and dependent children)

Please note that a payment will be made under this section only where, and to the extent that, in the Commission's opinion, it is not already covered by payments made under sections 9 (b)(iii) or 9 (b)(iv).

Name of victim ____

Sex of victim (M/F) ________ **Marital status** (victim) ______________________
single/married/widowed/co-habiting/other (specify)

Address where victim resided at time of death ____________________________

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Date of incident (DD/MM/YY) _____/_____/__________

Description and location of incident where fatal injury was sustained

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Was the incident reported to a relevant authority? Yes / No _________________

If yes, what relevant authority and when? _________________________________

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If fatal injury was sustained outside the State, please state

(i) length of time victim was then resident in the State ___________________

(ii) period(s) of residence in the State _______________________________

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(iii) address where the victim was resident in the State at the time of fatal injury suffered/occurred

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Proof of continuing economic hardship being suffered as a result of the bereavement (give details of all earnings - P60 / Statement of Social Welfare income / Private Pension payments etc. (for previous three years))

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If an application is being made in respect of an adult dependent child, give details of any assessment of dependency carried out (attach any reports)

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Any additional information or documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge. I give my permission to seek external confirmation or clarification of the information provided.

Signature _____________________________

Date ______________________________

Form RF4

APPLICATION FOR ECONOMIC HARDSHIP PAYMENT UNDER SECTION 9 (b) (ii) (permanent incapacity to work)

Please note that a payment will be made under this section only where, and to the extent that, in the Commission's opinion, it is not already covered by payments made under sections 9 (b)(iii), 9 (b)(iv) or 9 (c).

Name of Applicant ___________________________________ **Sex** (M/F) ________

Date of incident (DD/MM/YY) _____/_____/__________

Description and location of incident resulting in injury

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Was the incident reported to a relevant authority? __________________________

If yes, what relevant authority and when? _________________________________

Are you permanently incapable of working as a result of an injury or injuries sustained in the incident upon which your application is based?* (Yes / No) ____

Proof of being permanently incapable of working as a result of the injury or injuries sustained*

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If the incident occurred outside the State but you were resident in the State at the time of the incident, the address where you resided at the time of the incident

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Length of time resident at that address ___________________________________

If the incident occurred outside the State, and you were not resident in the State at the time of the incident but are currently resident here and have been for at least three years prior to the date of this application, please state your address/s in the State

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Length of time resident at your current address ____________________________

Copies of appropriate and relevant medical or other certificates should be submitted with this application.

Any additional information or documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge. I give my permission to seek external confirmation or clarification of the information provided.

Signature ____________________________

Date _______________________________

**Submit statement from Department of Social and Family Affairs, (or other equivalent Agency) re periods on Disability Benefit / Pension. Submit medical evidence supporting claim that absences were as a result of injuries sustained in incident. You must have been absent from work for a minimum continuous period of 1 year as a result of injuries sustained in the incident.*

Form RF5A

APPLICATION FOR DISPLACEMENT PAYMENT
UNDER SECTION 9 (b) (iii) OR 9 (b) (iv)
(Victim)

Name of Applicant ______________________________________ **Sex** (M/F) _____

Reason for Displacement

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Description and Location of incident which resulted in your displacement

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Date of incident (DD/MM/YY) _____/_____/__________

Was the reason for the displacement reported to a relevant authority? (Y/N) ___

If yes, what relevant authority and when? _________________________________

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Any injuries which were received ____

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Address from which you were displaced ___________________________________

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Address to which you were displaced _______________________________________

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Length of time at this address __________________________

Current Address ____

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Length of time at this address __________________________

Address to which you are returning ____

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Please forward details of the purchase or rental agreement regarding the premises to which you intend to return.

Proof of continuing economic hardship being suffered as a result of the displacement; (Give details of all earnings - P60/Details of Social Welfare/Private Pension payments etc.)____

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Any additional information or documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge. I give my permission to seek external confirmation or clarification of the information provided.

Signature ____________________________________ **Date** ____________________

<u>Form RF5B</u>

APPLICATION FOR DISPLACEMENT PAYMENT
UNDER SECTION 9 (b) (iii) OR 9 (b) (iv)
(Surviving spouse and children)

Name of victim ____

Sex of victim (M/F) ______________ **Marital Status** _______________________
single/married/widowed/co-habiting/other (specify)

Reason for Displacement ____

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Date of incident (DD/MM/YY) _____/_____/__________

Description and location of incident where the fatal injury was sustained

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Was the reason for the displacement reported to a relevant authority? (Y/N) ___

If yes, what relevant authority and when? _________________________________

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Address where victim resided at time of death ______________________________

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Address from which you were displaced ___________________________________

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Address to which you were displaced ______________________________________

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Length of time at this address _______________________________

Current Address ____

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Length of time at this address _______________________________

Address to which you are returning _____________________________________

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Please forward details of the purchase or rental agreement regarding the premises tp which you intend to return

Proof of continuing economic hardship being suffered as a result of the displacement; - (Give details of all earnings - P60/Details of Social Welfare/Private Pension payments etc.).

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Any additional information and documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge. I give my permission to seek external confirmation or clarification of the information provided.

Signature ______________________________

Date ________________________________

Form RF6

APPLICATION FOR MEDICAL PAYMENT UNDER SECTION 9 (c)
For injuries sustained as a result of an incident arising from the conflict in Northern Ireland

Payments will be made under this section only towards vouched unmet (unpaid) and continuing medical expenses, apart from exceptional cases.

An application will be considered where the medical expenses in respect of which the application is being made meet the following criteria:

- they are unpaid and will not be paid by another public body; and
- they are incurred since 29 October, 2003 (the date of appointment of the Commission).

The Commission may, at its discretion, make exceptional payments under this category as outlined in the Scheme and referred to on this form.

An application under this section must be certified by a qualified doctor.

Name of Applicant ______________________________________ **Sex** (M/F) _____

Description and location of incident resulting in injury

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Date of incident (DD/MM/YY) _____/_____/__________

Was the incident reported to a relevant authority? __________________________

If yes, what relevant authority and when? _________________________________

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If the incident occurred outside the State but you were resident in the State at the time of the incident, the address where you resided at the time of the incident

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Length of time resident at that address ____________________________________

If the incident occurred outside the State, and you were not resident in the State at the time of the incident but are currently and have been for at least three years prior to the date of this application resident in the State, please state your address/s in the State

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Length of time resident at your current address _____________________________

Details of unmet and continuing medical expenses ___________________________

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Please attach appropriate documentation** in support of the application.

Have you received any payment from any other source (ie VHI, HSA any other source) in respect of these medical expenses? Yes/No ___________

If yes please supply details of payments _____________________________________

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Are you applying for a payment to cover respite care (i.e. where alternative care is provided for a victim in order to enable a carer to take a break), prostheses or other such forms of assistance (please specify)? (Y/N) _______________________

If yes, attach appropriate documentation in support of the application

Are you applying for a once-off payment as an exceptional case, for example, because, in obtaining medical treatment prior to the commencement of the Scheme, you have amassed considerable debts which you consider you are likely to have great difficulty discharging? (Y/N) ________________________________
If yes, attach appropriate documentation in support of the application

Any additional information or documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge. I give my permission to seek external confirmation or clarification of the information provided.

Signature ________________________________

Date ___________________________________

<u>To be completed by a qualified medical doctor:</u>

I confirm that the information provided in this application is correct to the best of my knowledge and that the treatment/medical intervention been prescribed relates to an injury sustained as a result of the Northern Ireland conflict.

Signature _______________________________________

Name ____

Medical Qualifications ____

Address ____

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Date _______________________________

Form RF7

Application from Victim Support Group to the Remembrance Fund (Scheme of Acknowledgement, Remembrance and Assistance for Victims in this Jurisdiction of the Conflict in Northern Ireland)

The Scheme, which is attached at Appendix I, sets out the categories under which applications will be considered. Section 9 (d) sets out payments available to victim support groups.

Completed application forms should be forwarded to:

Secretary
Remembrance Commission
1A Lower Grand Canal Street
Dublin 2

Applicants may be asked to make a presentation to the Commission as part of the assessment of any application.

Name of group ____

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Address of group ____

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Contact details:

Name of contact person __________________________________

Telephone number ______________________________

Fax number ____________________________________

E-mail address ____

Group's charitable status ____

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Group's structure ____

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Supporting documentation should provide details of the following:

- Nature of services being provided and which it is intended will be provided (specify bereavement counselling, trauma management counselling, support network);

- Description of persons to whom services are being/will be offered;

- Current and proposed staffing numbers of group;

- Levels of qualifications, expertise and experience of staff of group;

- Current and proposed budget of group;

- Current and proposed sources of funding of group other than the Remembrance Fund.

Any further information and documentation which you consider would support this application should be enclosed with this form.

I confirm that the information provided in this application is correct to the best of my knowledge.

Signature __________________________________

Name __________________________________

Position in group ____

Date __________________________________