SEGURANÇA SOCIAL

Long-term Care Supplement

Application for the Long-term Care Supplement

○ 1st Application ○ Review of the benefit

1 Personal details of the beneficiary (dependent person)

Full name

Social Security Identification Number

Birth date (year - month - day)

Taxpayer no.

Mobile phone/Phone no.

Email

The beneficiary is applying for the supplement as a:

○ Pension applicant

○ Pensioner of:

Please state one of the following situations: Invalidity, Old-age/Survivor's Pension, Old-age Social Pension, Orphan's or Widow's/Widower's Pension

○ Social Inclusion Benefit holder

○ Non-pensioner beneficiary suffering from any of the diseases listed in table 8

2 Personal details of the applicant[1]

(To be completed if the application is not submitted by the beneficiary)

Full name

Social Security Identification Number

Birth date (year - month - day)

Taxpayer no.

Address

Locality

Postal Code

Mobile phone/Phone no.

Email

[1] Family members, other persons or institutions that provide or are available to provide assistance.

3 Details of the assistance provided

3.1. Type of assistance

☐ Performance of domestic services ☐ Mobility support ☐ Support in personal hygiene care

☐ Feeding support ☐ In a subsidised nursing home ☐ Other

3.2. Situation of the dependent person

☐ Bedridden ☐ Other

3 Details of the assistance provided (continuation)

3.3. Assistance provider

Person/institution providing assistance

Full name

Social Security Identification Number

Start date of the assistance provision
year - month - day

Address

Locality

Postal Code

Mobile phone/Phone no.

Email

Person/institution providing assistance

Full name

Social Security Identification Number

Start date of the assistance provision
year - month - day

Address

Locality

Postal Code

Mobile phone/Phone no.

Email

4 Other details concerning the dependent person

Are you self-employed or employed? ◯ Yes ◯ No

Have you been engaged in any gainful activity abroad, as a self-employed person or as an employee? ◯ Yes ◯ No

If you ticked Yes, please indicate:

Countries where you have worked	Period/s (year-month-day)	Insurance or Registration Number
	from - - to - -	
	from - - to - -	
	from - - to - -	

Do you receive pensions and/or care benefits from another body/bodies, national or foreign? ◯ Yes ◯ No

If you ticked Yes, please indicate:

Monthly amount	Paying authority/authorities
€	
€	
€	

Was the situation of dependency caused by an act of third-party responsibility? ◯ Yes ◯ No

If you answered Yes, you must submit form RP 5074 - Statement of Incapacity Caused by Third Party Intervention, duly completed, together with this application.

5 To be completed in case of review of the dependency degree

Grounds justifying the request:

6 Statements of the beneficiary/applicant

I am aware that false statements are punished according to the law.

I declare that the information I have provided is complete and true.

Date

year - month - day

Signature

Signature of the beneficiary/applicant or of another person on his/her behalf (signature of another person when the beneficiary/applicant cannot or does not know how to sign) according to a valid identification document.

7 Statements of the person providing assistance

I am aware that false statements are punished according to the law.

I declare that the information I have provided is complete and true.

Date

year - month - day

Signature

Signature of the person providing assistance or of another person on his/her behalf (signature of another person when the person providing assistance cannot or does not know how to sign) according to a valid identification document.

8 Information

Documents to submit

- Valid ID document (Citizen Card, Identity Card, Passport or Residence Permit) of the dependent person, the applicant and the person/s providing assistance.
- Valid ID document (Legal Person Identification Card) of the institution providing assistance.

Bank account

The payment of all your current or future benefits/allowances or persions will be made by bank transfer to the IBAN (International Bank Account Number) registered in the Social Security Information System.

If you have not registered your IBAN yet or if you want to update it, you can do so:

- Through the Social Security Online Service (*Segurança Social Direta*) at www.seg-social.pt.
- At the Social Security Customer Information Services, by submitting the Application form MG 14 - IBAN Registration or Change (*Requerimento de Registo ou Alteração de IBAN*).

If the IBAN registered is incorrect or if you do not have an IBAN registered in the system, the payment of all your current or future benefits/allowances or pensions will be made using the payment method that is registered in the Social Security information system.

Forms

The application forms are available on the Social Security Online Service (*Segurança Social Direta*) at www.seg-social.pt and at the Social Security Customer Information Services.

Information (continuation)

8

Where to submit the documents

The application and the additional mandatory documents must be submitted through the Social Security Online Service (*Segurança Social Direta*) at www.seg-social.pt or sent by post to a Social Security Service.

Notes

8.1. Who is entitled to the Long-term Care Supplement?

- Pensioner or applicant of Invalidity, Old-age or Survivor's Pension, Old-age or Survivor's Social Pension, Orphan's or Widow's/Widower's Pension.
- Non-pensioner beneficiary suffering from one of the following diseases: Familial amyloidotic plyneuropathy (FAP), Machado-Joseph disease, Human Immunodeficiency Virus (HIV), Multiple Sclerosis, Cancer, Amyotrophic Lateral Sclerosis, Parkinson's disease, Alzheimer's disease, rare diseases or others.
- Social Inclusion Benefit holder.

8.2. Who can provide assistance?

- One or more persons acting jointly, provided that they are not deprived of autonomy, including family members of the dependent person.
- Institutions providing home care or other services, namely telecare alarm services.
- Public or private social support establishments, whether profit-making or non-profit-making.

If you are summoned to undergo a medical examination to assess your dependency status, you must submit form SVI 7 - Medical Information, on the day of the examination.

Data protection

The collected data will be processed by the competent Social Security Services (*Instituto da Segurança Social, I.P.*, *Instituto da Segurança Social dos Açores, I.P.R.A.* and *Instituto de Segurança Social da Madeira, I.P.-RAM*) and will be kept for the period necessary to fulfil their intended purpose.
These Social Security services are committed to protecting your personal data and to fulfilling their obligations wihin the scope of data protection.
For further information on data protection, please consult the Social Security Online Service (*Segurança Social Direta*) at www.seg-social.pt.

To be completed by the Social Security services

I confirm that the signature/s of the ◯ **Applicant/s** ◯ **Person/s that signed on behalf of the applicant/s** are in accordance with the following identification document:

Beneficiary/Applicant

◯ Citizen Card ◯ Identity Card ◯ Passport ◯ Other

Number

Valid until (year - month - day)

Signature and stamp

Person providing assistance

◯ Citizen Card ◯ Identity Card ◯ Passport ◯ Other

Number

Valid until (year - month - day)

Signature and stamp