



Application Form

Long-Term Illness (LTI) Scheme

Free drugs, medicines, medical and surgical appliances for certain long-term illnesses.

The Long-Term Illness Scheme applies only to people who have been diagnosed with one or more of the following long-term diseases or disabilities covered by this scheme:

Acute Leukaemia	Diabetes Mellitus Does not include Gestational Diabetes	Intellectual Disability (Described in legislation as Mental Handicap.)	Parkinsonism
Cerebral Palsy	Epilepsy	Mental Illness (Under 16 years)	Phenylketonuria
Cystic Fibrosis	Haemophilia	Multiple Sclerosis	Spina Bifida
Diabetes Insipidus	Hydrocephalus	Muscular Dystrophies	Thalidomide Conditions

There are two sections to this application form:

Section 1 - should be completed by the applicant (or by a parent or guardian signing on behalf of the applicant). Please ensure this section is completed in block capitals.

Section 2 - should be completed by a healthcare professional (for example, your GP or hospital consultant).

Completed application forms should be returned to your local community health organisation.

Section 1 – Applicant – Personal De	tails
First name(s):	Surname:
Date of birth: D D M M Y Y Y Y	Birth surname:
PPS number: (Mandatory)	Gender: Male Female
Address:	Mobile phone: – – – – – – – – – – – – – – – – – – –
	Daytime phone:
	Email address:

Section 1A – N	Section 1A – Nominated Pharmacy																					
Name:																						
Address:																						
(Please note this is optional.)																						
If you wish, you can give	If you wish, you can give us the name of the pharmacy you use. This will allow us to get in touch with them if there is any																					

If you wish, you can give us the name of the pharmacy you use. This will allow us to get in touch with them if there is any drug-related information we need to share. If you would rather not name a pharmacy, just leave this area blank.

Section 1B – Your	GP	's (det	ail	s									
Name:														
Address:														

Section 1C – Declaration and Consent

I am applying for eligibility under the Long-Term Illness Scheme.

I declare that the information I have given is correct to the best of my knowledge.

I agree that my pharmacist may contact the HSE to confirm that the prescribed medicines are approved under the scheme.

If it applies, I confirm that I am the parent or legal guardian of the named applicant, and I give consent on their behalf.

If you are signing on behalf of the applicant, please complete the details below																			
Your name: Block Capitals																			
Relationship to applicant:																			

Section 1D – Data Protection and Freedom of Information Notice

The HSE will treat all personal information and data you provide as part of this application, as confidential and store it securely.

When the HSE receives the completed application form, it will make a computer record for the named applicant.

This record will contain the relevant personal information you have supplied.

This personal record will be used and kept by the HSE, solely for the purposes of processing your Long-Term Illness application.

The HSE will not disclose (share) to other people or organisations the personal information you have given unless consent has been given by the person authorised to give this consent, or if the HSE is required to do so by law.

Section 2	2 – Cer	tifi	ca	tic	n	by	G	en	era	al I	Pra	act	iti	on	er	or	Ho	osp	oita	al (Co	ns	ult	an	t	
I certify that	Name:																									

has one or more of the prescribed diseases or disabilities of a permanent or long-term nature covered by Section(3) of the Health Act 1970 (as amended) that are listed on page 1.

Please tick all illnesses that apply as that will influence what drugs, medicines, medical and surgical appliances are provided free to the eligible person.

Acute Leukaemia	Diabetes Mellitus Does not include Gestational Diabetes	Intellectual Disability (Described in legislation as Mental Handicap.)	Parkinsonism	
Cerebral Palsy	Epilepsy	Mental Illness (Under 16 years)	Phenylketonuria	
Cystic Fibrosis	Haemophilia	Multiple Sclerosis	Spina Bifida	
Diabetes Insipidus	Hydrocephalus	Muscular Dystrophies	Thalidomide Conditions	

The following drugs, medicines, medical and surgical appliances are needed to treat the prescribed disease(s)/ disability:

Drug/Medicine (include strength and pharmaceutical form	m /Medical and surgical appliance*
1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

Signature:	Docto	r's Stamp
	General Practitioner/Hospital Consultant	
Name:		
Medical Council No.	Date: D D M M Y Y Y	

* Non consumable surgical appliances (equipment) are organised through your Community Health Organisation (Local Office)



For official use

LTI No. _

Approval Date: _

Official Use Only – Decision of Health Service Executive

The following drugs, medicines, medical and surgical appliances listed under the line items on page 3 of this form by the applicant's GP or hospital consultant are hereby **approved**.

Signed:														Da	te:	D	D	Μ	М	Y	Y	Y	Y
Authorised Officer														Со	ntact	No:							
Name:																							
GMS No. of pharmacy (i	fon	e is :	state	ed):																			
Date of approval:								D	D	Μ	Μ	Y	Y	Y	Y								
Effective date of eligibility:								D	D	М	М	Y	Y	Y	Y								
Date dispatched to Primary	/ Car	e Re	imbu	ursen	nent	t Servi	ce:	D	D	М	М	Y	Y	Y	Υ								
Date entered on local of	fice	LTI s	syste	em:				D	D	М	М	Y	Y	Y	Y								

