Reset form

Kela

Application

EV 256e

Care allowance for pensioners/
Disability allowance for persons aged 16 years or over

You can also complete the application and file related documentation online at www.kela.fi/omakela (in Finnish) or www.fpa.fi/mittfpa (in Swedish).
More information is available at www.kela.fi/disability

If you have questions, please call our customer service number (www.kela.fi/call-kela).

Please make sure to complete the form carefully. Attach all necessary documentation.
We may contact you for further information if necessary.
Send the application and any supporting documents by mail. The address is Kela, PL 10, 00056 KELA.

ⓘ You need to enclose a medical statement with your application. The medical statement must not be older than 6 months.
If you have moved to Finland and you have not previously claimed benefits from Kela, also complete form Y 77e.
If you are going abroad, also complete form Y 38e.

When to apply: The benefit can be backdated by a maximum of 6 months from the date of application.

1. Applicant

Personal identity code

Family name and given name

Street address

Postal code

Postal district

Telephone

E-mail

Country of residence

☐ Finland ☐ Other country; please specify.

Have you lived or worked in some other country than Finland in the previous 3 years?

☐ No ☐ Yes; please specify in which country and when.

Are you

☐ Retired ☐ Working/Unemployed ☐ A student ☐ Other; please specify.

Occupation:

2. Bank account number

ⓘ The benefit is paid to an adult customer's own bank account, unless a legal representative has been assigned to the customer. The benefit to a minor is paid to the bank account stated by the customer's guardian or legal representative.

☐ Customer's own bank account number

☐ Bank account number stated by the legal representative or a minor's legal guardian

Bank account number:

3. Application

ⓘ You don't have to indicate separately if you are applying for a review or an extension of an allowance that is currently paid out.
If you receive a pension on the basis of old age or full incapacity for work, you cannot apply for disability allowance for persons aged 16 years or over.

This application is for

☐ Care allowance for pensioners ☐ Disability allowance for persons aged 16 years or over

☐ I give my consent for Kela to, on the basis of this application, issue a decision to me on the disability benefits I am entitled to, when needed.

4. Pensions and compensations from other sources

Do you receive or are you applying for a pension from some other country than Finland?

☐ No ☐ Yes; specify the pension and the payer.

Do you receive or are you applying for a benefit that corresponds to care allowance or disability allowance from some other country?

☐ No ☐ Yes; specify the benefit and the payer.

Do you receive or are you applying for compensation on the grounds of disability from an insurance company in Finland or in some other country?

☐ No ☐ Yes; specify the benefit and the payer.

5. Illnesses and disabilities and their treatment

Which illnesses or disabilities make your everyday life more difficult?

When did your functional ability start deteriorating?

At which healthcare facilities do you usually receive treatment?

Do you receive treatment or rehabilitation prescribed by a doctor (e.g. physical therapy or psychotherapy) for your illness or disability?

☐ No ☐ Yes; specify the type of treatment or rehabilitation and how often.

ⓘ Also state when the treatment or rehabilitation started and for how long it will continue.

6. Need of assistance, guidance and supervision

ⓘ If you need more space, continue at section 9 (Additional information).

How much and what type of assistance or guidance and supervision do you need

When moving indoors or outdoors (e.g. when starting to move)?

☐ I don't need assistance or guidance and supervision.

ⓘ Also state if you use assistive devices when moving or if you need supervision in order not to get lost or fall.

With dressing/undressing or personal hygiene (e.g. washing or going to the toilet)?

☐ I don't need assistance or guidance and supervision.

ⓘ Also state if you need reminding.

With eating?

☐ I don't need assistance or guidance and supervision.

With seeing, hearing or speaking?

☐ I don't need assistance or guidance and supervision.

ⓘ Also state if you use assistive devices for seeing, hearing or communication or if you need an interpreter. If you use assistive devices or you need an interpreter, please specify the type of assistance you need and the type of situations in which you need assistance.

To remember things?

☐ I don't need assistance or guidance and supervision.

In the treatment of the illness (e.g. taking medication)?

☐ I don't need assistance or guidance and supervision.

With household activities, cooking or running errands outside the home?

☐ I don't need assistance or guidance and supervision.

With something else; please specify.

7. Receiving assistance

ⓘ Tick the appropriate alternatives and write the requested information.

From whom do you get assistance?

☐ From no one ☐ From a family member ☐ From a personal assistant

☐ From home help staff/an in-home nurse ☐ From the staff in the residential care home

☐ A cleaner visits _____ times per month.

☐ I use shopping service _____ times per month.

☐ I use meal service _____ times per week.

☐ I have a security telephone.

☐ Other assistance; please specify from whom. _____

How much assistance do you get?

ⓘ Instead of stating the number of hours, you can also state how many times per week or per day you get assistance. Describe the amount of assistance you get as exactly as possible.

☐ I get assistance weekly. For how many hours per week? _____

☐ I get assistance daily. For how many hours per day? _____

When did you start to get assistance / when did you start to need more assistance?

For how long do you think you can safely manage on your own?

☐ Over a whole 24-hour period ☐ Over the night ☐ Only for a couple of hours ☐ I cannot manage on my own at all

8. Costs

ⓘ Costs caused by the illness or disability may mean that the allowance is increased from allowance at the basic rate to allowance at the middle rate. The costs must be incurred for at least 6 months and be necessary due to the illness or disability.

Please state in the following if you have costs due to the illness or disability. If you have such costs, specify the costs and their amount per year. We may request further information as needed.

Kela already has information about costs for which you have received reimbursement from Kela. Such costs include e.g. costs for medicines, travels related to health care and private medical care services reimbursed by Kela.

Do you have costs due to the illness or disability?

☐ No ☐ Yes

☐ Care fee for assisted living	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Home care/home health care	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Cleaning service	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Shopping service	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Transport fee for meal service	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Visits to a doctor	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Rehabilitation and treatment prescribed by a doctor	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Recurring hospital fees	EUR _____	per year	or EUR _____	per month, start date: _____
☐ Medicines that are not reimbursed by Kela	EUR _____	per year	or EUR _____	per month, start date: _____

☐ Travel costs related to health care or rehabilitation which have not been reimbursed by Kela EUR _____ per year or EUR _____ per month, start date: _____

☐ Other support service; please specify

_____ EUR _____ per year or EUR _____ per month, start date: _____

Do you have a service voucher?

☐ No ☐ Yes

9. Additional information

ⓘ Write the number of the section you are referring to.

10. Enclosures

ⓘ You need to enclose a medical statement C with your application. A medical statement B or other medical documentation can also be accepted, if it includes the information needed to make a decision on the application. The statement must have been issued within the last approximately 6 months.

☐ The statement has already been submitted to Kela.

☐ I will submit the medical statement by _____ .

11. Signature

☐ I give my consent to have additional information needed for the application requested from the person mentioned in section 12 who helped to complete the application.

I declare that the information I have given is true and accurate. I will notify any changes.

Place and date Signature

ⓘ If the beneficiary is under 18 years of age:

- the application must include the signature or phone number of the guardian or legal representative. The phone number can be stated under section 9.
- the benefit is paid to the bank account stated by the guardian or legal representative. The decision will also be sent to the guardian. Separate decisions will be sent to guardians who live at different addresses (section 5 of the Act on Child Custody and Right of Access).

12. Person helping the applicant to complete the application

Name and telephone number

Official position and place of work or family relationship to the applicant

Information obtained for the purpose of deciding the present matter may be used for other benefit-related matters, if so required under law. Any information obtained within the context of another benefit may also be used to decide the present matter.

Please contact us for more information about which outside sources we may access to obtain additional information about your circumstances and to whom we may provide such information.