SG ENABLE
Inclusive society, Enabled lives.

APPLICATION FOR

ADULTS DISABILITY SERVICES

Before you fill in this form, please take note:

- Please refer to the eligibility criteria for each service from SG Enable website before completing the attached application form.
- The application form (16 pages) is to be submitted with supporting documents as indicated in the instructions.
- Upon receipt of your application form and supporting documents, SG Enable will acknowledge the receipt of the application via email / call.
- Application form must be completed and submitted by post, fax or email:

By Post : SG Enable – Adult Disability Services
20 Lengkok Bahru
#01-01
Singapore 159053

By Email : ad.services@sgenable.sg

Supporting Documents

☑ Clear **photocopy of the applicant's NRIC** (Front and Back) or **Birth Certificate**[1]

☑ Clear **photocopy of the next-of-kin's NRIC** (Front and Back) for applicants who are below 21 years old or who are mentally incapacitated.

☑ SG Enable **Application Form**

☑ Latest **medical report**[3] **/ Psychological report** stating the type of disability.

☑ Latest **Social Report**[4]

☑ Clear **photocopy of the Court Order / Lasting Power of Attorney** and **NRIC of the deputy(s) / Donee(s),** if applicable

Important Information

- Consent / Declaration must be signed by Applicant aged 21 and above on page 14. For applicants who are below 21, the parent or legal guardian must give consent on behalf on page 14. If the main applicant is mentally incapacitated, the appointed deputy(s) / donee(s) must give consent on behalf and doctor's certification is required on page 14. A copy of the Court Order / Lasting Power of Attorney and NRIC of the deputy(s) / Donee(s) need to be submitted with application. For family member / guardian who is unable to provide consent on behalf, please complete the section "Unable to provide consent on Behalf" on page 14.
- SG Enable reserves the right to reject any application that is incomplete or without the required documents.

[1] For Permanent Residents, at least one immediate family members[2] of the applicants must be a Singapore Citizen.
[2] Immediate family members refer to parents or siblings of the applicants.

[3] Social worker of the referring agency may complete the medical background of the applicant, page 15 and 16 of the form if a medical report is submitted with the application. **If no medical report is submitted**, page 15 and 16 of the form should be filled by a Singapore Registered Medical Practitioner.

[4] The social report should include the applicant's psychosocial background and issues: Genogram, family support, source of assistance, applicant's current living condition, educational/ employment background, reasons for application, social worker's assessment and recommendation and other relevant descriptions. The social report should be type-written.

01 July 2016

APPLICATION FOR ADULTS DISABILITY SERVICES

Please tick ☑ where appropriate.

PART 1 - SERVICE REQUIRED

SERVICES (For Singaporeans or Permanent Residents+ only)		Long-term	Short-term	DURATION	
				FROM	TO
COMMUNITY BASED SERVICES	❑ Sheltered Workshop				
	❑ Day Activity Centre	❑			
			❑		
	❑ Drop-in Disability Programme				
	❑ Home Based Care Services (Pilot)				
STAY-IN FACILITIES	❑ Adult Disability Home	❑			
			❑		
	❑ Children Disability Home	❑			
			❑		
	❑ Adult Disability Hostel	❑			
			❑		
	❑ Community Group Home				

+ *Require at least one immediate family member who is a Singapore citizen.*
^ *Homes also provide short term and long term care for persons aged below 16.*

PART 2 – PARTICULARS OF APPLICANT

Family Name:

Given Name:

NRIC/Birth Cert No.

*Citizenship: ❑ Singaporean ❑ Permanent Resident

D.O.B D D / M M / Y Y Y Y

*Gender: ❑ Male ❑ Female

Contact (Mobile):

Contact (if any):

Address: _____

_____ Postal Code: S

Email (if any): _____

Race: ❑ Chinese ❑ Malay ❑ Indian ❑ Others: _____

Language(s) Spoken: ❑ English ❑ Chinese ❑ Malay ❑ Tamil ❑ Others, please specify: _____

PART 3 – CURRENT LIVING ARRANGEMENT

❑ Living alone ❑ Living with Family / Relative ❑ Others, please specify: _____

Type of Accommodation:

❑ HDB Flat (_____ - room)

❑ Private, please specify: _____

❑ Institution (eg. Hospital): _____ Ward / Bed: _____ / _____

Duration of stay: _____ to _____

❑ Others, please specify: _____

PART 4 – SOURCE OF FINANCIAL SUPPORT

	Amount (S$)		**Amount (S$)**
❑ Family	_____	❑ Public Assistance (PA no: _____)	_____
❑ Gross Employment Income	_____	❑ Organisation (please specify: _____	_____
❑ Savings	_____	❑ Others (please specify): _____	_____

PART 5 – EDUCATIONAL HISTORY

From	To	Name of School / Institution	Qualifications	Reasons for Leaving

PART 6 – EMPLOYMENT HISTORY (INCLUDING SHELTERED WORKSHOP)

From	To	Name of Company / Institution	Qualifications	Reasons for Leaving

PART 7 – PARTICULARS OF MAIN CONTACT PERSON
(FOR APPLICANTS WHO ARE BELOW 21 YEARS OLD OR LACK MENTAL CAPACITY TO ACT)

Family Name:

Given Name:

NRIC/Birth Cert No.

*Citizenship: ☐ Singaporean ☐ Permanent Resident

D.O.B D D / M M / Y Y Y Y

*Gender: ☐ Male ☐ Female

Contact (Mobile):

Contact (Home):

*Relationship with applicant: ❑ Parent ❑ Legal Guardian ❑ Deputy ❑ Donee ❑ Others, please specify: _____

Address (if different from applicant): _____

Postal Code: S

Email: _____

Occupation: _____

Language(s) Spoken: ❑ English ❑ Chinese ❑ Malay ❑ Tamil ❑ Others, please specify: _____

PART 8 – PARTICULARS OF SECONDARY CONTACT PERSON
(FOR APPLICANTS WHO ARE BELOW 21 YEARS OLD OR LACK MENTAL CAPACITY TO ACT)

Family Name:

Given Name:

NRIC/Birth Cert No.

*Citizenship: ☐ Singaporean ☐ Permanent Resident

D.O.B D D / M M / Y Y Y Y

*Gender: ☐ Male ☐ Female

Contact (Mobile):

Contact (Home):

*Relationship with applicant: ❑ Parent ❑ Legal Guardian ❑ Deputy ❑ Donee

Address (if different from applicant): _____

Postal Code: S

Email: _____

Occupation: _____

Language(s) Spoken: ❑ English ❑ Chinese ❑ Malay ❑ Tamil ❑ Others, please specify: _____

PART 9 – PARTICULARS OF FAMILY MEMBERS

No.	Full Name	NRIC / BC No.	Age	Contact No.	Relationship with Applicant	Stays with Applicant	Occupation (if applicable)	Monthly Gross Income (S$)
1						❑ Y ❑ N		
2						❑ Y ❑ N		
3						❑ Y ❑ N		
4						❑ Y ❑ N		
5						❑ Y ❑ N		
6						❑ Y ❑ N		
7						❑ Y ❑ N		
8						❑ Y ❑ N		
9						❑ Y ❑ N		
10						❑ Y ❑ N		

PART 10 – ASSESSMENT			
Please select where appropriate.			
	Rating *(please circle the rating)*		***Client's Needs (Please tick if client is not rated 'A'; more than one prompt may be ticked)***
Q1 MOBILITY	A	Requires no supervision/assistance	☐ Needs supervision, assistance or need instructions to move around ☐ Needs supervision or physical guidance by staff in the use of assistive devices e.g., walking frame, quad stick or wheelchair ☐ Needs pushing/positioning of wheelchair to meals/toilet/centre activities ☐ Wheel chair bound - needs positioning/transfer from wheelchair to toilet commode/dining chair ☐ _____
	B	Requires some supervision (on assistive device)/some physical assistance	
	C	Requires significant supervision (on assistive device)/significant physical assistance	
	D	Totally dependent on staff	
Q2 FEEDING	A	Requires no supervision/assistance	☐ Needs supervision because of poor ability to self-feed or messy eating ☐ Needs positioning on chair ☐ Needs assistance to cut up food into suitable portions at the dining table ☐ Needs supervision to prevent choking / food grabbing from visitors or at meal times ☐ Needs assistance for refusal to eat due to withdrawn or depressed behaviour ☐ Needs encouragement or assistance to feed self ☐ _____
	B	Requires supervision/some physical assistance	
	C	Requires significant supervision/significant physical assistance	
	D	Totally dependent on staff	
Q3 TOILETING (*excludes transferring client to wheelchair for toileting)	A	Requires no supervision/assistance	☐ Needs supervision to commence/complete toileting ☐ Needs supervision/assistance in positioning over toilet receptacle ☐ Needs assistance with undressing and dressing, clothing adjustments or change of clothes/diapers ☐ Needs reminders/supervision to flush toilet after use ☐ Needs reminders/supervision/assistance to clean self after toileting ☐ Needs supervision/assistance in cleaning after episodes of incontinence ☐ _____
	B	Requires some supervision/some physical assistance	
	C	Requires significant physical assistance	
	D	Totally dependent on staff	
Q4 PERSONAL GROOMING & HYGIENE (*excludes cleaning/changing after incontinence)	A	Requires no supervision/assistance	☐ Needs constant reminders/assistance to be neat in attire ☐ Needs constant reminders/assistance to wipe mouth after meals ☐ Needs constant reminders to bathe ☐ Needs supervision/assistance due to general self-neglect ☐ Need supervision/assistance with selection of appropriate clothing ☐ Need supervision/assistance with combing of hair ☐ Need supervision/assistance with shaving ☐ Need assistance with trimming of finger and toe nails ☐ Need supervision/assistance with dressing, putting on slippers etc. ☐ Need supervision/assistance with brushing of teeth, cleaning and fitting dentures and other oral care ☐ Need supervision/assistance with sanitary napkins during menstruation ☐ Needs supervision/assistance with soaping, washing, drying ☐ _____
	B	Requires supervision/some physical assistance for grooming/hygiene activities	
	C	Requires significant physical assistance for grooming/hygiene activities	
	D	Totally dependent on staff	

Please select where appropriate.

		Rating *(please circle the rating)*	*Client's Needs (Please tick if client is not rated 'A'; more than one prompt may be ticked)*
Q5 TREATMENT (*excludes psychological interventions)	A	No medical/nursing/occupational therapy/physiotherapy needs	☐ Supervised/assisted medication (oral/topical) and/or injection ☐ Simple nursing procedure ☐ Coaxing, prompting for medication/injection/ nursing/OT/PT refusal ☐ OT/PT *(if this prompt is ticked, please rate 'D' only)* OT: ☐ Individual ☐ Group — PT: ☐ Individual ☐ Group ☐ Complex nursing procedure Duration: _____ minutes Frequency: _____ times per day/week/month* (*please circle*)
	B	Supervised/assisted medication and/or injection **AND/OR** Simple nursing procedure **ONLY**	
	C	Supervised/assisted medication with coaxing required and/or injection with coaxing required **AND/OR** Simple nursing procedure with coaxing required **ONLY**	
	D	Occupational therapy/physiotherapy **AND/OR** Complex/specialised nursing procedure	
Q6 SOCIAL & EMOTIONAL NEEDS (*excludes needs associated with confusion, behavioural and/or psychiatric problems)	A	No evidence of need	☐ Encouragement to participate in DAC activities ☐ Assurance to adjust to DAC routines ☐ Support to families of clients ☐ Comforting clients who are distressed ☐ _____
	B	Occasional need (1-3 times a week)	
	C	Frequent need (4-6 times a week)	
	D	Always (Daily)	
Q7 CONFUSION Disorientation To Place / Person	A	No evidence of confusion	☐ Not oriented to place or person* ☐ _____ **Client has displayed / is displaying signs of disorientation, such as being unable to recognise familiar people or places.* *Disorientation may occur as a result of delirium, dementia, stroke, head injury, epilepsy, other conditions causing tissue damage and trauma.*
	B	History of confusion but no such behaviour in past month	
	C	Occasional display of confusion (1-3 times a week)	
	D	Often - always display of confusion (≥4 times a week)	
Q8 PSYCHIATRIC PROBLEMS (No Formal Diagnosis Needed)	A	No evidence of problem	☐ Hallucinations – e.g. hear and/or responds to voices ☐ Delusions – e.g. is suspicious, accuses others of causing harm ☐ Anxiety – e.g. anxious and tense – e.g. preoccupied with physical symptoms/ complaints ☐ Depression – e.g. lacks interest in daily activities – e.g. tearful, easily upset – e.g. agitated ☐ _____
	B	History of psychiatric problem(s) but no observable symptoms currently **OR** Some suspicion of underlying psychiatric problem(s)	
	C	Current mild interference in functioning (requires some supervision)	
	D	Current moderate - severe interference in functioning (requires medical/ psychological intervention)	

Please **select where appropriate.**			
	Rating ***(please circle the rating)***		***Client's Needs*** ***(Please tick if client is not rated 'A'; more than one prompt may be ticked)***
Q9a BEHAVIOURAL PROBLEMS - DISRUPTIVE BEHAVIOUR	A	No behavioural support needed: No evidence of past/current disruptive behaviour	☐ Shouting, screaming ☐ Tantrums, anger control problems, irritability ☐ Hyperactivity, impulse control problems ☐ Oppositional ☐ Sexually disinhibited behaviour (e.g. Stripping, masturbation) ☐ Absconding, wandering ☐ Inappropriate speech/vocalisation ☐ Inappropriate social behaviour ☐ Other disruptive behaviour _____
	B	Minimal behavioural support needed: History of past disruptive behaviour but no current problem	
	C	Moderate behavioural support needed: Occasional display of disruptive behaviour (1-3 times a week) **OR** Mild level of disruptive behaviour (requires some supervision)	
	D	Significant behavioural support needed: Often - always display of disruptive behaviour (≥4 times a week) **OR** Moderate - severe level of disruptive behaviour (requires medical/ psychological intervention)	
Q9b. BEHAVIOURAL PROBLEMS - STEREOTYPIC BEHAVIOUR	A	No behavioural support needed: No evidence of past/current stereotypic behaviour	☐ Hand-flapping or waving ☐ Head-rolling ☐ Body-rocking ☐ Spinning or flipping of objects ☐ Sniffing objects ☐ Repetitive hand or finger movements ☐ Repetitive vocal sequences or screaming (if the behaviour is stereotypical and not rated under "Disruptive Behaviour") ☐ Other stereotypic behaviour _____
	B	Minimal behavioural support needed: History of past stereotypic behaviour but no current problem	
	C	Moderate behavioural support needed: Occasional display of stereotypic behaviour (1-3 times a week) **OR** Mild level of stereotypic behaviour (requires some supervision)	
	D	Significant behavioural support needed: Often - always display of stereotypic behaviour (≥4 times a week) **OR** Moderate - severe level of stereotypic behaviour (requires medical/ psychological intervention)	

Please select where appropriate.			
	Rating *(please circle the rating)*		***Client's Needs*** ***(Please tick if client is not rated 'A'; more than one prompt may be ticked)***
***Q10a. RISK BEHAVIOURS - AGGRESSION**	A	No behavioural support needed: No evidence of past/current aggressive behaviour	☐ Verbal aggression ☐ Property destruction ☐ Body slamming ☐ Physical aggression towards staff, strangers, other clients (e.g., punching, hitting, biting, kicking with body contact) ☐ Sexual aggression or abusive behaviour ☐ Other aggressive behaviour _____
	B	Minimal behavioural support needed: History of past aggressive behaviour but no current problem	
	C	Moderate behavioural support needed: Occasional display of aggressive behaviour (1-3 times a week) **OR** Mild level of aggressive behaviour (requires some supervision)	
	D	Significant behavioural support needed: Often - always display of aggressive behaviour (≥4 times a week) **OR** Moderate - severe level of aggressive behaviour (requires medical/ psychological intervention)	
***Q10b RISK BEHAVIOURS - SELF INJURIOUS OR SUICIDAL BEHAVIOUR**	A	No behavioural support needed: No evidence of past/current self-harm/ suicidal behaviour	☐ Self-mutilation (e.g. head banging, hair-pulling, skin-picking, self-biting, self-scratching) ☐ Inserting fingers or objects into body orifices ☐ Pica, extreme drinking ☐ Intentional risk-taking and reckless behaviours ☐ Attempted suicide ☐ Other self-harming behaviour _____
	B	Minimal behavioural support needed: History of past self-harm/suicidal behaviour but no current problem	
	C	Moderate behavioural support needed: Occasional display of self-harm/suicidal behaviour (1-3 times a week) **OR** Mild level of self-harm/suicidal behaviour (requires some supervision)	
	D	Significant behavioural support needed: Often - always display of self-harm/suicidal behaviour (≥4 times a week) **OR** Moderate - severe level of self-harm/ suicidal behaviour (requires medical/ psychological intervention)	

Please **select where appropriate.**			
	Rating ***(please circle the rating)***		***Client's Needs*** ***(Start by considering 'A' first; only consider the subsequent option if the earlier criteria is not met)***
Q11a COMMUNITY LIVING NEEDS - TASK ORIENTATION	A	No support needed in task orientation	Must be able to focus attention & engage in repetitive tasks continuously for more than 1 hour, **AND** ☐ Work on task without supervision ☐ Work on task with minimum supervision *(tick at least 1)*
	B	Minimal support needed in task orientation	Must be able to focus attention & engage in repetitive tasks continuously for ½ -1 hour, **AND** ☐ Follow instructions ☐ Respond to corrections ☐ Ask for help *(tick at least 2)*
	C	Moderate support needed in task orientation	Must be able to focus attention & engage in repetitive task continuously for 10 - 30 minutes, **AND** ☐ Follow instructions ☐ Retrieve/keep task-related tools/materials *(tick at least 1)*
	D	Significant support needed in task orientation	☐ Unable to focus attention & engage in repetitive task continuously for more than 10 minutes ☐ Unable to follow instructions & retrieve/keep task-related tools/materials *(tick at least 1)*
Q11b COMMUNICATION NEEDS - COMMUNICATION NEEDS (RECEPTIVE & EXPRESSIVE)	A	No support needed for communication	RECEPTIVE ☐ Understand multi-step instructions EXPRESSIVE ☐ Relate (verbal/non-verbal) experiences when asked *(tick all)*
	B	Minimal support needed for communication	RECEPTIVE ☐ Understand 2-step instructions EXPRESSIVE ☐ Ask (verbal/non-verbal) simple questions ☐ Make request for things or for help *(tick 1 receptive & 1 expressive)*
	C	Moderate support needed for communication	RECEPTIVE ☐ Understand 1-step instructions EXPRESSIVE ☐ Indicate yes/no (verbal/non-verbal) to simple question ☐ Protest against intrusions to personal space/desire *(tick at least 1)*
	D	Significant support needed for communication	RECEPTIVE ☐ Unable to understand 1-step instructions EXPRESSIVE ☐ Unable to indicate yes/no (verbal/non-verbal) to simple question ☐ Unable to protest against intrusions to personal space/desire *(tick all)*

Please **select where appropriate.**			
	Rating ***(please circle the rating)***		***Client's Needs*** ***(Start by considering 'A' first; only consider the subsequent option if the earlier criteria is not met)***
Q11c COMMUNITY LIVING NEEDS - TIME MANAGEMENT	A	No support needed for time management	☐ Follow timetable of daily routine without supervision *(tick all)*
	B	Minimal support needed for time management	☐ Tell time, day, or date ☐ Recognise and follow sequence of scheduled activities with/without prompting *(tick all)*
	C	Moderate support needed for time management	☐ Follow sequence of scheduled activities only with prompting *(tick all)*
	D	Significant support needed for time management	☐ Unable to follow the sequence of scheduled activities even with prompting *(tick all)*
Q11 d COMMUNITY LIVING NEEDS - GETTING AROUND	A	No supervision/support needed to get to familiar destinations in the community	☐ Use EZ link card (if applicable) ☐ Recognise landmarks ☐ Follow safety rules ☐ Behave appropriately in public *(tick all)*
	B	Minimal supervision/support needed to get to familiar destinations in the community	☐ Use EZ link card (if applicable) ☐ Recognise landmarks ☐ Follow safety rules ☐ Behave appropriately in public *(tick at least 2)*
	C	Moderate supervision/support needed to get to familiar destinations in the community	☐ Recognise landmarks ☐ Follow safety rules ☐ Behave appropriately in public *(tick at least 1)*
	D	Significant supervision/ support needed to get to familiar destinations in the community	☐ Unable to recognise landmarks ☐ Unable to follow safety rules ☐ Unable to behave appropriately in public *(tick all)*
Q11e COMMUNITY LIVING NEEDS - MANAGING $	A	No supervision/support needed to handle money	☐ Consider price when making a purchase ☐ Receive correct change ☐ Give appropriate amount when making payment ☐ Store money for safekeeping *(tick all)*
	B	Minimal supervision/support needed to handle money	☐ Consider price when making a purchase ☐ Receive correct change ☐ Give appropriate amount when making payment ☐ Store money for safekeeping *(tick at least 3)*
	C	Moderate supervision/support needed to handle money	☐ Receive correct change ☐ Wait to receive change ☐ Give appropriate amount when making payment ☐ Store money for safekeeping *(tick at least 2)*
	D	Significant supervision/support needed to handle money	☐ No concept of money ☐ Unable to handle money due to physical limitation *(tick at least 1)*

Please select where appropriate.			
	Rating *(please circle the rating)*		***Client's Needs* *(Start by considering 'A' first; only consider the subsequent option if the earlier criteria is not met)***
Q11f COMMUNITY LIVING NEEDS - LEISURE/RECREATION	A	No supervision/support needed to engage in leisure/recreational activities	☐ Play board/card games or sports that require simple rules ☐ Participate in outings and comply with both safety & conventional rules of etiquette *(Tick at least 1)*
	B	Minimal supervision/support needed to engage in leisure/recreational activities	☐ Play board/card games or sports that require simple rules ☐ Participate in outings and comply with safety rules ☐ Participate in outings and comply with conventional rules of etiquette *(Tick at least 1)*
	C	Moderate supervision/support needed to engage in leisure/recreational activities	☐ Play board/card games or sports that require simple rules ☐ Play board/card games or sports that have no rules / listen to music/watch television ☐ Participate in outings with significant supervision *(Tick at least 1)*
	D	Significant supervision/support needed to engage in leisure/recreational activities	☐ Unable to play any board/card games or sports, listen to music or watch television ☐ Unable to participate in outings even with significant supervision *(Tick all)*
Q11g COMMUNITY LIVING NEEDS - SOCIAL FUNCTIONING	A	No supervision/support needed to interact socially	☐ Communicate with others (verbal/gestures) ☐ Behave appropriately to others ☐ Demonstrate appropriate level of physical contact ☐ Participate in group activities ☐ Wait for turn ☐ Greet others (self-initiated/in response) ☐ Respond to name ☐ Tolerate proximity to others *(Tick all)*
	B	Minimal supervision/support needed to interact socially	☐ Communicate with others (verbal/gestures) ☐ Behave appropriately to others ☐ Demonstrate appropriate level of physical contact ☐ Participate in group activities ☐ Wait for turn *(Tick at least 3)*
	C	Moderate supervision/support needed to interact socially	☐ Participate in group activities ☐ Wait for turn ☐ Greet others (self-initiated/in response) ☐ Respond to name ☐ Tolerate proximity to others *(Tick at least 2)*
	D	Significant supervision/support needed to interact socially	☐ Unable to participate in group activities ☐ Unable to wait for turn ☐ Unable to greet others (self-initiated/in response) ☐ Unable to respond to name ☐ Unable to tolerate proximity to others *(Tick at least 4)*

Assessed by	
Agency:	Date of Assessment:
Name of staff:	Tel. (DID):
Designation:	Tel. (HP):
Email:	

PART 11 – DECLARATION BY REFERRING ORGANISATION

By using the services offered by SG Enable and by providing or making available ours or our clients' personal information and such other information about us or our clients to SG Enable and/or MSF and continuing to do all of the above, we represent and warrant that:

1. The information given in this application is true and correct to the best of our knowledge and those of each of our individual clients and contains all relevant information and matters that ought to be disclosed by us to SG Enable whether for ourselves or for our clients.

2. We and each of our clients have read and understood all of the provisions herein and we hereby represent that we have been duly authorised by and have the requisite authority to make the application, execute such documents and do all necessary acts including the disclosure of such personal information, on our clients' or our organisation's behalf and that each of our clients has given their consent for SG Enable and/or MSF to use their personal data including but not limited to names, NRICs, contact numbers, mailing and email addresses as well as other information for the purposes of the programme run by SG Enable as well as any applicable supplementary programmes at SG Enable's discretion and the purposes that are set out in SG Enable's Privacy Policy which can be found on its website at https://www.sgenable.sg as well as MSF's Privacy Statement which can be found on its website at http://www.msf.gov.sg and each of them shall provide their consent in favour of SGE Enable and/or MSF in relation to the above.

3. We and each of our clients are aware that SG Enable has the complete and sole discretion in considering our or our clients' eligibility for the programme in question and SG Enable may without providing any reasons or explanations, revoke its approval of any application by us at any time without prior notice and such decisions and acts or omissions of SG Enable shall be conclusive, final and binding on us or our clients including such right on the part of SG Enable to recover in full any subsidy disbursed to us arising from this application if we or any of our clients have provided inaccurate information, or withheld any relevant information required for this application.

4. We and each of our clients understand that SG Enable and/or MSF will take all reasonable measures to protect our and our clients' information from unauthorised access or against loss, misuse or alteration by third parties.

5. We agree that in no event will SG Enable and/or MSF be liable to us or our clients for any losses or damages, loss of income, profit or savings or indirect, incidental, special, consequential, or punitive damages arising from or in connection with our application.

6. We and each of our clients have been advised that we may withdraw our consent to SG Enable and/or MSF in respect of the use of our personal data by providing such reasonable notice to SG Enable and/or MSF as well as to direct any queries we may have, including any request to delete data which have been obtained from them or from third parties or to opt out of any messages, emails, newsletters or other marketing or promotional materials to us or our clients, to the designated person, email or contact persons as indicated in SG Enable's Privacy Policy or MSF's Privacy Statement.

Being the person disclosing the information and making the application for the purposes as set out above or being duly authorised by such persons disclosing the information and making the application for the purposes as set out above, hereby agree to the above.

Name of Staff	Name of Organisation
Signature	Date

PART 12 – CONSENT/ DECLARATION BY MAIN APPLICANT / AUTHORISED PERSON

Please tick ☑ where appropriate

1. I declare that the information given in this application is true and correct to the best of my knowledge.
2. I have read and understood all of the provisions herein and I hereby give my consent for SG Enable and/or MSF to use my or my ward's personal data including but not limited to my name, NRIC, contact number, mailing and email address as well as other information for such purposes of the present programme run by SG Enable as well as any applicable supplementary programme at SG Enable's discretion and the purposes that are set out in SG Enable's Privacy Policy which can be found on its website at https://www.sgenable.sg as well as MSF's Privacy Statement which can be found on its website at http://www.msf.gov.sg.
3. I am aware that SG Enable has the right to recover in full any subsidy disbursed to me arising from this application if I have provided inaccurate information, or withheld any relevant information required for this application.
4. I understand that SG Enable and/or MSF will take all reasonable measures to protect my or my ward's information from unauthorised access or against loss, misuse or alteration by third parties.
5. I have been advised that I may withdraw my consent to SG Enable and/or MSF in respect of the use of my or my ward's personal data by providing such reasonable notice to SG Enable and/or MSF as well as to direct any queries I may have, including any request to delete data that have been obtained from me or my ward or from third parties or to opt out of any messages, emails, newsletters or other marketing or promotional materials sent to me or my ward, to the designated person, email or contact persons as indicated in SG Enable's Privacy Policy or MSF's Privacy Statement.

12 a - Consent / Declaration by Applicant

(Please proceed to 12 b and complete 12 d if Applicant is unable to give consent)

I hereby confirm that I understand and agree to all the provisions in this form.

Name of Applicant (as in NRIC / BC)	Signature / Thumbprint	Date (DD/MM/YYYY)

12 b - Consent / Declaration by Authorised Person

(Please proceed to 12 c "Unable to Provide Consent On Behalf" if no one can provide consent / declaration on behalf)

❑ I have consented on behalf of Applicant who is under 21 years of age.
❑ I/ We have consented on behalf of the Applicant who is permanently mentally incapacitated. **(Doctor to complete section 12d)**

Name of signatory 1	Signature / Thumbprint	Date (DD/MM/YYYY)

Name of signatory 2 (If joint consent is required)	Signature / Thumbprint	Date (DD/MM/YYYY)

12 c - Unable to Provide Consent On Behalf of Applicant

The following family member / guardian (aged 21 and above) is unable to provide consent on behalf of the Applicant.

Name (as in NRIC / BC): _____ NRIC No.: _____

Reason for inability to provide consent on behalf

❑ Applicant is permanently mentally incapacitated, however a deputy has not been appointed by the Court under the Mental Capacity Act (Cap. 177A) / donee has not been appointed under a Lasting Power of Attorney. **(Doctor to complete section 12d)**

❑ Others (Please specify): _____

12 d - Doctor's Certification for Mental Incapacity

(For applicant who is aged 21 and above and is permanently mentally incapacitated)

I certified that the Applicant, _____ (Name) _____ (NRIC No.) is **permanently mentally incapacitated** and is **unable to provide consent on his/ her**: **(Please select one of the below options)**

❑ Personal welfare ❑ Property and Financial matters ❑ Personal welfare, Property and Financial matters

Name of Doctor		Signature of Doctor	Official stamp of hospital/ clinic:
Date (DD/MM/YYYY)	MCR No.	Contact No.	

Instructions:
If the doctor is not present to certify and sign this form, a separate doctor's memo indicating that the Applicant is unable to provide consent due to relevant medical reason may be attached.

PART 13 - MEDICAL INFORMATION (page 1 of 2)

Social worker of the referring agency may assist in providing the medical background of the applicant on page 14 and 15, if a medical report is submitted for the application. If no medical report is submitted, this assessment should only be filled up by a fully registered medical practitioner.

Name of Applicant: _____ NRIC / BC No.: _____

Please tick ☑ where appropriate.

TYPE OF DISABILITY (Multiple selection allowed for multiple disabilities condition)			**PRIMARY DIAGNOSIS**
Diagnosis	Intellectual Disability (IQ level: below 70)	Borderline ID (IQ level: 70 – 80)	
❑ Intellectual Condition	❑	❑	❑

Diagnosis	**Partial Impairment**	**Total Impairment**	**PRIMARY DIAGNOSIS**
❑ Sensory (Visual) : _____	❑	❑	❑
❑ Sensory (Hearing): _____	❑	❑	❑
❑ Sensory (Others) : _____	❑	❑	❑

Diagnosis	**Mild**	**Moderate**	**Severe**	**PRIMARY DIAGNOSIS**
❑ Autism Spectrum Disorder (ASD)	❑	❑	❑	❑
❑ Physical Disability (Please specify): _____	❑	❑	❑	❑
❑ Developmental Condition (Please specify): _____	❑	❑	❑	❑
❑ Other Disabilities (Please specify): _____	❑	❑	❑	❑

MEDICAL HISTORY

(a) Mental or psychiatric disorders

❑ No – *Please move on to Question (b)* ❑ Yes, please specify: _____

Condition: ❑ Mild ❑ Moderate ❑ Severe

(b) Infectious diseases

❑ No – *Please move on to Question (c)* ❑ Yes, please specify: _____

Following up: ❑ Yes ❑ No ❑ Discharged ❑ Defaulted

Date of last follow-up: _____ Hospital / clinic: _____

Condition: ❑ Active or highly contagious ❑ Persistent and asymptomatic ❑ No longer infectious or contagious

DOCTOR'S CERTIFICATION - IF APPLICABLE (page 1 of 2)

Name of Doctor		Signature of Doctor	Official stamp of hospital/ clinic:
Date (DD/MM/YYYY)	MCR No.	Contact No.	

MEDICAL INFORMATION (page 2 of 2)

Social worker of the referring agency may assist in providing the medical background of the applicant on page 14 and 15, if a medical report is submitted for the application. If no medical report is submitted, this assessment should only be filled up by a fully registered medical practitioner.

Name of Applicant: _____ NRIC / BC No.: _____

Please tick ☑ where appropriate.

(c) Medical conditions

- ❑ Respiratory: _____
- ❑ Cardiovascular: _____
- ❑ Endocrine / Metabolic: _____
- ❑ Neurological disorders: _____
- ❑ Musculoskeletal: _____
- ❑ Dermatological conditions: _____
- ❑ Other condition(s) not specified above: _____

If any of the above is ticked, please elaborate (e.g. frequency of occurrence): _____

_____

(d) Did patient undergo any surgery within the last two years? If yes, please provide brief details:

	Date	**Surgery done**
❑ No ❑ Yes		

(e) Is patient currently on any medication?

	If yes, please specify:	
❑ No ❑ Yes	1.	6.
	2.	7.
	3.	8.
	4.	9.
	5.	10.

(f) Does patient have any drug allergies?

	If yes, please specify:	
❑ No ❑ Yes	1.	3.
	2.	4.

(g) Does patient have any regular follow-ups?

	If yes, please specify:	
	Types of follow up	**Frequency**
❑ No ❑ Yes		

DOCTOR'S CERTIFICATION - IF APPLICABLE (page 2 of 2)

Name of Doctor		Signature of Doctor	Official stamp of hospital/ clinic:
Date (DD/MM/YYYY)	MCR No.	Contact No.	