SG ENABLE
Inclusive society, Enabled lives.

APPLICATION FOR ADULT DISABILITY SERVICES

BEFORE YOU FILL IN THIS FORM, PLEASE TAKE NOTE:

- The Adult Disability Services help adults with disabilities find support services that enable them to achieve and maintain better health and independence.
- To apply for Adult Disability Services, please submit the attached application form to us together with all the required supporting documents.
- The instructions for completing and submitting the application form are provided on the next page.
- SG Enable reserves the right to reject any application that is incomplete or is not supported by the required documents.

CONTACT US:

Infoline: 1800 858 5885
Website: www.sgenable.sg

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ADULT DISABILITY SERVICES
(Please Retain this page for your information)

ELIGIBILITY

Please refer to the eligibility criteria for each service from SG Enable website before completing the attached application form.

SUPPORTING DOCUMENTS

- Clear photocopy of the applicant's NRIC (Front and Back) or Birth Certificate1
- 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
- Proof of Disability[3] (A Psychological Report is required for applications to Sheltered Workshop)
- Latest Medical Report[4] (Only applicable for applicants with any past or presenting medical condition)
- Latest Social Report[5]
- Clear photocopy of the Court Order / Lasting Power of Attorney and NRIC (Front and Back) of the deputy(s)/donee(s), if applicable

IMPORTANT NOTES

- The Declaration and Consent section on pages 17 must be signed by the applicant. For applicants who are below 21, the parent or legal guardian must give consent on behalf on page 18. If the applicant is mentally incapacitated, the appointed deputy(s)/donee(s) must give consent on behalf of the applicant and a doctor's certification is required on pages 18. A copy of the Court Order/Lasting Power of Attorney and NRIC of the deputy(s)/Donee(s) must be submitted with the application. For family members/guardians who are unable to provide consent on behalf of the applicant, please complete the section "Unable to provide consent on Behalf" on page 18.
- Upon receipt of the completed application form and all supporting documents, SG Enable will acknowledge the receipt of the application via email/phone call.

SEND APPLICATION TO

Mailing Address:	SG Enable – Adult Disability Services 20 Lengkok Bahru, #01-01, Singapore 159053
Email:	ad.services@sgenable.sg

1. For Permanent Residents, at least one immediate family member[2] of the applicant must be a Singapore Citizen.
2. Immediate family members refer to spouses, parents, children of the applicant, including step-parents and step-children.
3. May accept disability diagnosis report/ memo/ medical discharge summary from Singapore Registered Medical Practitioner that proof or certify the applicant's disability.
   Medical Information (page 19 and 20) is not mandatory if applicant has any medical proof of his/ her disability condition (stated above) and does not have any past or presenting health condition.
4. For applicant who has past or presenting medical condition without any attached medical report, applicant may approach a Singapore Registered Medical Practitioner to assess and complete the Medical Information (page 19 and 20).
   A social worker from the referring agency may complete the medical background of the applicant (page 19 and 20 of the form) to share more information of the applicant's medical background, if an attached medical report is sufficient to proof the applicant's disability and medical condition.
5. The social report should include the applicant's psychosocial background and issues: Genogram, family support, source of assistance, applicants' current living condition, educational/employment background, reasons for application, social worker's assessment and recommendation, and other relevant descriptions. The social report should be typewritten.

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Please tick ⊘ where applicable

A. SERVICE REQUIRED

SERVICES (For Singaporean or Permanent Residents+ Only)		Long-term	Short-term	Duration	
				From	To
COMMUNITY-BASED SERVICES	☐ Sheltered Workshop				
	☐ Day Activity Centre (DAC) ^	☐			
			☐		
	☐ Drop-in Disability Programme (DDP)				
STAY-IN FACILITIES	☐ Adult Disability Home (ADH) ^	☐			
			☐		
	☐ Children Disability Home (CDH) #	☐			
			☐		
	☐ Adult Disability Hostel (AD Hostel) ^	☐			
			☐		
	☐ Community Group Home (CDH)				

+ At least one immediate family member must be a Singapore Citizen
^ Services providing short-term and long-term care
# Children Disability Home provides short-term and long-term care of persons aged below 16

B. APPLICANT'S PARTICULARS

Name: (Mr/Mrs/Mdm/Ms/ Miss)*

Identification Type: ○ NRIC - Singapore Citizen, Permanent Resident ○ Foreign Identification Number — Identification Number

Citizenship: ○ Singaporean ○ Permanent Resident ○ Others

Date of Birth: (DD/MM/YYYY) / /

Gender: ○ Male ○ Female

Preferred Spoken Language: ○ English ○ Mandarin ○ Malay ○ Tamil ○ Others (Please Specify) _____

Race: ○ Chinese ○ Malay ○ Indian ○ Others (Please Specify) _____

Contact (Home):

Contact (Mobile):

Contact (Office):

Email: _____

Address:

Postal Code: S

Unit No.: # -

Please tick ⊘ where applicable

C. CURRENT LIVING ARRANGEMENTS

○ Living alone ○ Living with Family / Relative ○ Others (Please Specify) _____

Type of Accommodation:

○ HDB Flat (_____-rooms)

○ Private (Please Specify) _____

○ Institution (e.g. Hospital) _____ Ward/Bed: _____ / _____

Duration of Stay: _____ to _____

○ Others (Please Specify) _____

D. SOURCE OF FINANCIAL SUPPORT

	Amount (S$)		Amount (S$)
○ Family	_____	○ Public Assistance (PA No.: _____)	_____
○ Gross Employment Income	_____	○ Organization (Please Specify: _____)	_____
○ Savings	_____	○ Others (Please Specify: _____)	_____

E. EDUCATIONAL HISTORY

From	To	Name of School	Qualifications	Reasons for Leaving

F. EMPLOYMENT HISTORY

(Including Sheltered Workshop)

From	To	Name of School	Qualifications	Reasons for Leaving

Please tick ⊘ where applicable

G. PARTICULARS OF CONTACT PERSONS

Particulars of Primary Contact Person

Name:

Identification Number: **Date of Birth:** / /

Citizenship: ○ Singaporean ○ Permanent Resident ○ Others **Gender:** ○ Male ○ Female

Preferred Spoken Language: ○ English ○ Mandarin ○ Malay ○ Tamil ○ Others (Please Specify) _____

Race: ○ Chinese ○ Malay ○ Indian ○ Others (Please Specify) _____

Relationship:

Guardianship: ○ Deputy ○ Donee ○ Legal Guardian

Contact (Home): **Contact (Mobile):**

Contact (Office): **Email:** _____

Postal Code: S **Unit No.:** # -

Occupation / Job Title: **Gross Monthly Income:** $

Particulars of Secondary Contact Person

Name:

Identification Number: **Date of Birth:** / /

Citizenship: ○ Singaporean ○ Permanent Resident ○ Others **Gender:** ○ Male ○ Female

Preferred Spoken Language: ○ English ○ Mandarin ○ Malay ○ Tamil ○ Others (Please Specify) _____

Race: ○ Chinese ○ Malay ○ Indian ○ Others (Please Specify) _____

Relationship:

Guardianship: ○ Deputy ○ Donee ○ Legal Guardian

Contact (Home): **Contact (Mobile):**

Contact (Office): **Email:** _____

Postal Code: S **Unit No.:** # -

Occupation / Job Title: **Gross Monthly Income:** $

Please tick ⊘ where applicable

H. PARTICULARS OF FAMILY MEMBERS

No.	Full Name	NRIC / Birth Cert No.	Date of Birth	Citizenship	Contact Number	Relationship to Applicant	Postal Code	Floor & Unit	Occupation	Monthly Gross Income (SGD)
1				○ Singaporean ○ Permanent Resident ○ Others						
2				○ Singaporean ○ Permanent Resident ○ Others						
3				○ Singaporean ○ Permanent Resident ○ Others						
4				○ Singaporean ○ Permanent Resident ○ Others						
5				○ Singaporean ○ Permanent Resident ○ Others						
6				○ Singaporean ○ Permanent Resident ○ Others						
7				○ Singaporean ○ Permanent Resident ○ Others						
8				○ Singaporean ○ Permanent Resident ○ Others						
9				○ Singaporean ○ Permanent Resident ○ Others						
10				○ Singaporean ○ Permanent Resident ○ Others						

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Please tick ⊘ where applicable

Name of Applicant: _____

NRIC / BC No.: _____

I. ASSESSMENT

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q1 MOBILITY	Rating ○ **A** Requires no support for mobility in day-to-day routines	☐ Needs supervision, assistance or 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 ☐ _____
	Rating ○ **B** Requires some support for mobility in day-to-day routines	
	Rating ○ **C** Requires significant support for mobility in day-to-day routines	
	Rating ○ **D** Totally dependent on staff for mobility in day-to-day routines	
Q2 FEEDING	Rating ○ **A** Requires no support to feed	☐ 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 ☐ _____
	Rating ○ **B** Requires Some Support to feed	
	Rating ○ **C** Requires significant support to feed	
	Rating ○ **D** Totally dependent on staff to feed	
Q3 TOILETING (*excludes transferring person to wheelchair for toileting)	Rating ○ **A** Requires no support for toileting	☐ 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 ☐ _____
	Rating ○ **B** Requires some support for toileting	
	Rating ○ **C** Requires significant support for toileting	
	Rating ○ **D** Totally dependent on staff for toileting	

Please tick ⊘ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q4 PERSONAL GROOMING & HYGIENE (*excludes cleaning/changing after incontinence)	Rating ○ **A** Requires no support for grooming or hygiene	☐ 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 ☐ _____
	Rating ○ **B** Requires some support for grooming or hygiene	
	Rating ○ **C** Requires significant support for grooming or hygiene	
	Rating ○ **D** Totally dependent on staff for grooming or hygiene	
Q5 PSYCHIATRIC PROBLEMS (No Formal Diagnosis Needed)	Rating ○ **A** Requires no support for the specified mental health 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 or preoccupied with physical symptoms/ complaints ☐ Depression e.g. lacks interest in daily activities, tearful, easily upset, agitated ☐ _____
	Rating ○ **B** Requires support to monitor the specified mental health problem (in view of history) **OR** Requires support to follow up with psychiatric evaluation due to suspicion of mental health problem	
	Rating ○ **C** Requires behavioural support to deal with <u>mild interference</u> in mental health functioning.	
	Rating ○ **D** Requires behavioural support to deal with moderate – severe interference in mental health functioning	

Please tick ⊘ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q6a BEHAVIOURAL PROBLEMS DISRUPTIVE BEHAVIOUR	**Rating ○ A** Requires no support (i.e., no evidence of past and 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: _____ ☐ How recently did the behaviour last occur? (e.g. Within Last 30 days / More than 30 days ago) _____ ☐ Frequency in which the behaviour(s) occurred: (e.g. 1-3 times a week / >4 times a week) _____
	Rating ○ B Requires support to monitor for the presence of disruptive behaviour (in view of history)	
	Rating ○ C Requires behavioural support to deal with occasional (1-3 times a week) display of disruptive behaviour **OR** Requires behavioural support to deal with mild level of disruptive behaviour	
	Rating ○ D Requires significant behavioural support to deal with frequent display of disruptive behaviour (>4 times a week) **OR** Requires behavioural support to deal with moderate - severe level of disruptive behaviour	
Q6b. BEHAVIOURAL PROBLEMS STEREOTYPIC BEHAVIOUR	**Rating ○ A** Requires no support (i.e., no evidence of past and 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: _____ ☐ How recently did the behaviour last occur? (e.g. Within Last 30 days / More than 30 days ago) _____ ☐ Frequency in which the behaviour(s) occurred: (e.g. 1-3 times a week / >4 times a week) _____
	Rating ○ B Requires support to monitor for the presence of stereotypic behaviours (in view of history)	
	Rating ○ C Requires behavioural support to deal with occasional (1-3 times a week) display of stereotypic behaviour OR Requires behavioural support to deal with mild level of stereotypic behaviour	
	Rating ○ D Requires significant behavioural support to deal with frequent (>4 times a week) display of stereotypic behaviour OR Requires behavioural support to deal with moderate - severe level of stereotypic behaviour	

Please tick ⊘ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q7a. RISK BEHAVIOURS AGGRESSION	**Rating ○ A** Requires no support (i.e., no evidence of past and current aggressive behaviour)	
	Rating ○ B Requires support to monitor for the presence of aggressive behaviours (in view of history)	☐ Verbal aggression ☐ Property destruction ☐ Body slamming ☐ Physical aggression towards staff, strangers, other persons (e.g., punching, hitting, biting, kicking with body contact) ☐ Sexual aggression or abusive behaviour ☐ Other aggressive behaviour: _____ ☐ How recently did the behaviour last occur? (e.g. Within Last 30 days / More than 30 days ago) _____ ☐ Frequency in which the behaviour(s) occurred: (e.g. 1-3 times a week / >4 times a week) _____
	Rating ○ C Requires behavioural support to deal with occasional (1-3 times a week) display of aggressive behaviour **OR** Requires behavioural support to deal with mild level of aggressive behaviour	
	Rating ○ D Requires behavioural support to deal with frequent (>4 times a week) display of aggressive behaviour **OR** Requires behavioural support to deal with moderate - severe level of aggressive behaviour	
*Q7b. RISK BEHAVIOURS SELF INJURIOUS OR SUICIDAL BEHAVIOUR	**Rating ○ A** Requires no support (i.e., no evidence of past and current self-harm/suicidal behaviour)	
	Rating ○ B Requires support to monitor for the presence of self-harm/suicidal behaviour (in view of history)	☐ Self-mutilation (e.g. head banging, hair-pulling, skinpicking, 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: _____ ☐ How recently did the behaviour last occur? (e.g. Within Last 30 days / More than 30 days ago) _____ ☐ Frequency in which the behaviour(s) occurred: (e.g. 1-3 times a week / >4 times a week) _____
	Rating ○ C Requires behavioural support to deal with occasional display of self-harm/ suicidal behaviour (1-3 times a week) **OR** Requires behavioural support to deal with mild level of self-harm/suicidal behaviour	
	Rating ○ D Requires behavioural support to deal with the frequent (>4 times a week) display of self-harm/suicidal behavior **OR** Requires behavioural support to deal with moderate - severe level of self-harm/suicidal behaviour	

Please tick ☑ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q8 COMMUNITY LIVING NEEDS TASK ORIENTATION	Rating ○ **A** Requires no support to engage in learning a task	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)*
	Rating ○ **B** Requires some support to engage in learning a task	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)*
	Rating ○ **C** Requires moderate support to engage in learning a task	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)*
	Rating ○ **D** Requires significant support to engage in learning a task	☐ 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)*
Q9 COMMUNITY LIVING NEEDS COMMUNICATION NEEDS (RECEPTIVE & EXPRESSIVE)	Rating ○ **A** Requires no communication support	RECEPTIVE ☐ Understand multistep instructions EXPRESSIVE ☐ Relate (verbal/non-verbal) experiences when asked *(tick all)*
	Rating ○ **B** Requires minimal communication support	RECEPTIVE ☐ Understand 2-step instructions EXPRESSIVE ☐ Ask (verbal/non-verbal) simple questions ☐ Make request for things or for help *(tick 1 receptive & 1 expressive)*
	Rating ○ **C** Requires moderate communication support	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)*
	Rating ○ **D** Requires significant communication support	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 tick ⊘ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q10 COMMUNITY LIVING NEEDS TIME MANAGEMENT	Rating ○ **A** Requires no support to manage time on a daily basis	☐ Able to tell time, date, & day ☐ Follow timetable of daily routine without supervision *(tick all)*
	Rating ○ **B** Requires minimal support to manage time on a daily basis	☐ Tell time, day, or date ☐ Recognise and follow sequence of scheduled activities with/without prompting *(tick all)*
	Rating ○ **C** Requires moderate support to manage time on a daily basis	☐ Follow sequence of scheduled activities only with prompting *(tick all)*
	Rating ○ **D** Requires significant support to manage time on a daily basis	☐ Unable to follow the sequence of scheduled activities even with prompting *(tick all)*
Q11 COMMUNITY LIVING NEEDS GETTING AROUND	Rating ○ **A** Requires no support to get to familiar destinations in the community	☐ Use EZ link card (if applicable) ☐ Recognise familiar places ☐ Follow safety rules ☐ Behave appropriately in public *(tick all)*
	Rating ○ **B** Requires minimal support to get to familiar destinations in the community	☐ Use EZ link card (if applicable) ☐ Recognise familiar places ☐ Follow safety rules ☐ Behave appropriately in public *(tick at least 2)*
	Rating ○ **C** Requires moderate support to get to familiar destinations in the community	☐ Recognise familiar places ☐ Follow safety rules ☐ Behave appropriately in public *(tick at least 1)*
	Rating ○ **D** Requires significant support to get to familiar destinations in the community	☐ Unable to recognise familiar places ☐ Unable to follow safety rules ☐ Unable to behave appropriately in public *(tick all)*

Please tick ⊘ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q12 COMMUNITY LIVING NEEDS MANAGING MONEY	Rating ○ **A** Requires no support to handle money	☐ Consider price when making a purchase ☐ Receive correct change ☐ Give appropriate amount when making payment ☐ Store money for safekeeping *(tick all)*
	Rating ○ **B** Requires minimal support 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)*
	Rating ○ **C** Requires moderate support to handle money	☐ Receive correct change ☐ Wait to receive change ☐ Give appropriate amount when making payment ☐ Store money for safekeeping *(tick at least 2)*
	Rating ○ **D** Requires significant support to handle money	☐ No concept of money ☐ Unable to handle money due to physical limitation *(tick at least 1)*
Q13 COMMUNITY LIVING NEEDS LEISURE/RECREATION	Rating ○ **A** Requires no support to engage in leisure/recreational activities	☐ Play board/card games or sports that requires simple rules ☐ Participate in outings and comply with both safety & conventional rules of etiquette *(tick at least 1)*
	Rating ○ **B** Requires minimal support to engage in leisure/recreational activities	☐ Play board/card games or sports that requires simple rules ☐ Participate in outings and comply with safety rules ☐ Participate in outings and comply with conventional rules of etiquette *(tick at least 1)*
	Rating ○ **C** Requires moderate support to engage in leisure/recreational activities	☐ Play board/card games or sports that requires 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)*
	Rating ○ **D** Requires significant support 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)*

Please tick ⊘ where applicable

I. ASSESSMENT (CONTINUED)

	Rating	Person's Needs (Please tick if person is not rated 'A'; more than one prompt may be ticked)
Q14 COMMUNITY LIVING NEEDS SOCIAL FUNCTIONING	Rating ○ **A** Requires no support to interact socially	☐ Initiate/ respond to interactions (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)*
	Rating ○ **B** Requires minimal support to interact socially	☐ Initiate/ respond to interactions (verbal/gestures) ☐ Behave appropriately to others ☐ Demonstrate appropriate level of physical contact ☐ Participate in group activities ☐ Wait for turn *(tick at least 3)*
	Rating ○ **C** Requires moderate support 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)*
	Rating ○ **D** Requires significant support 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)*

J. ASSESSED BY

Agency:	_____	Date of Referral:	_____
Name of Referral Staff:	_____	Tel No. (DID):	_____
Designation:	_____	Tel No. (HP):	_____
Email:	_____		

Please tick ⊘ where applicable

K. 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

Please tick ⊘ where applicable

L. DECLARATION AND CONSENT

I declare that the information given in this application is true and correct to the best of my knowledge.

1. 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**.
2. 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/persons as indicated in SG Enable's Privacy Policy.
3. 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.
4. I give my consent for SG Enable to share the information provided with other relevant agencies for the purposes of my application, and/or the administration and provision of services and schemes to me, and/or data analysis, evaluation and policy formulation in which I shall not be identified as a specific individual.
5. I also consent to SG Enable to obtain information from the doctor from whom the applicant has consulted or any parties deemed related for the purposes of verifying the eligibility status of the applicant, and I authorise the doctor / related parties to release such information to SG Enable.
6. I have not willfully suppressed or provided any false information. I acknowledge that SG Enable reserves the right to reject my application without any reasons disclosed.

1L. DECLARATION AND CONSENT BY APPLICANT

(Please proceed to 4L and complete 4L 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

Consent/Declaration must be signed by Applicant aged 21 and above. If the Applicant is below 21, the parent or legal guardian must give consent on behalf in section 2L.

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APPLICATION FOR ADULT DISABILITY SERVICES

Please tick ⊘ where applicable

Name of Applicant: _____

NRIC / BC No.: _____

L. DECLARATION AND CONSENT (CONTINUED)

2L. DECLARATION AND CONSENT PROVIDED ON BEHALF OF APPLICANT

(Please proceed to Section 3L "Unable to Provide Consent on Behalf" if no one can provide consent/declaration on behalf)

○ I am the parent/ legal guardian and have declared on the behalf of Applicant who is under 21 years of age.[1]

○ I/We have declared on behalf of the Applicant who is mentally incapacitated.[2]

Name of Authorized Person 1	Signature/Thumbprint	Date
Name of Authorized Person 2 (If joint consent is required)	Signature/Thumbprint	Date

Instructions:

1. If the Applicant is below 21, the parent or legal guardian must give consent on behalf. Please provide a copy of the NRIC of the parent/ legal guardian as part of the application.
2. If the deputy(s)/donee(s) are required to act jointly, all deputy(s)/donee(s) must provide consent on behalf of the Applicant. Please provide a copy of the Court Order/Lasting Power of Attorney and NRIC of the deputy(s)/donee(s) as part of the application. Doctor's certification is required on the section 4L. "Doctor's Certification for Mental Incapacity" for applicant who is mentally incapacitated.

3L. UNABLE TO PROVIDE CONSENT ON BEHALF OF APPLICANT

(Please proceed to Section 4L "Doctor's Certification for Mental incapacity")

○ No Available authorized person to provide consent for applicant (aged 21 and above) who:

A. Is unable to provide consent due to his/her permanent mental incapacity;
B. Has no deputy(s) appointed to act for him/her by the court under the Mental Capacity Act (Cap. 177A) / donee(s) appointed to act for him/her under a lasting Power of Attorney

4L. DOCTOR'S CERTIFICATION FOR MENTAL INCAPACITY

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

I certify that the Applicant, _____ (Name of Applicant as in NRIC/BC), _____ (NRIC No.) is permanently mentally incapacitated and is unable to provide consent for his/her:

○ Personal Welfare ○ Property and Financial Matters ○ Personal Welfare, Property and Financial Matters

Name of Doctor	Signature.	Date
Contact No	MCR No.	Official Stamp of Hospital/Clinic

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.

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APPLICATION FOR ADULT DISABILITY SERVICES

Please tick ⊘ where applicable

Name of Applicant: _____

NRIC / BC No.: _____

M. MEDICAL INFORMATION

Medical Information is not mandatory if the applicant has any medical proof of his/ her disability condition and does not have any past or presenting health condition. Otherwise, applicant may approach a medical practitioner to complete the Medical Information.

A social worker from the referring agency may share additional medical background of the applicant on page 18 and 19, if a medical report is submitted together for the application.

1M. TYPE OF DISABILITY (Multiple Selection Allowed)

Diagnosis	Intellectual Disability (IQ: Below 70)	Borderline ID (IQ:70 - 80)	Primary Diagnosis
☐ Intellectual Condition	○	○	○

Diagnosis	Partial Impairment	Total Impairment	Primary Diagnosis
☐ Sensory (Visual):	○	○	○
☐ Sensory (Hearing):	○	○	○
☐ Sensory (Others):	○	○	○

Diagnosis	Mild	Moderate	Severe	Primary Diagnosis
☐ Sensory (Others):	○	○	○	○
☐ Physical Disability (Please Specify):	○	○	○	○
☐ Developmental Condition (Please Specify):	○	○	○	○
☐ Others (Please Specify):	○	○	○	○

2M. MEDICAL HISTORY

(a) Mental or psychiatric disorders

○ No ○ Yes, Please Specify: _____

Condition ○ Mild ○ Moderate ○ Severe

(b) Infectious Diseases

○ No ○ 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

Please tick ⊘ where applicable

M. MEDICAL INFORMATION (CONTINUED)

(c) Medical Conditions

☐ Respiratory: _____ ☐ Neurological Disorder: _____

☐ Cardiovascular: _____ ☐ Musculoskeletal: _____

☐ Endocrine/Metabolic: _____ ☐ Dermatological Conditions: _____

☐ Other condition(s) not specified above: _____

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

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

	Date	Surgery Done
○ No ○ Yes		

(e) Is the patient currently on any medication? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(f) Does the patient have any drug allergies? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(g) Does the patient have any food allergies? If yes, please specify below.

○ No ○ Yes	1.	3.
	2.	4.

(h) Does the patient have any regular follow-ups? If yes, please specify below.

	Types of follow-up	Frequency
○ No ○ Yes		

3M. DOCTOR'S CERTIFICATION – IF APPLICABLE

Name of Doctor	Signature.	Date
Contact No	MCR No.	Official Stamp of Hospital/Clinic