SG ENABLE
Inclusive society. Enabled lives.

# APPLICATION FORM: ASSISTIVE TECHNOLOGY FUND

BEFORE YOU FILL IN THIS FORM, PLEASE TAKE NOTE:

## ABOUT ATF

- The Assistive Technology Fund (ATF) provides subsidies for Persons with Disabilities (PWDs) to purchase assistive technology devices to enable independent living.
- A successful applicant qualifies for a subsidy of up to 90% of the cost of assistive technology devices, subject to a cap of $40,000 over the applicant's lifetime. The subsidy amount is means-tested.

## INSTRUCTIONS TO TOUCHPOINTS

- Applicants will require the assistance of an Application Admin (e.g. Social Worker) and an Assessor (e.g. Therapist) from Touchpoints such as Hospitals and Social Service Agencies to complete this application. The Application Admin will submit this application on behalf of the applicant.
- The Application Admin must submit a copy of the Disability Verification Form (DVF), completed by a relevant Registered Healthcare Professionals from Public Hospitals or Social Service Agencies, if the applicant's disability status has not been verified or they have a new disability condition which has not been pre-verified previously. The applicants may check if their disability status have been verified by logging into SupportGoWhere with their Singpass: https://supportgowhere.life.gov.sg/grants/pwdr/apply.
- Registered Touchpoints are requested to submit the application directly via the eService portal.
- The instructions for completing and submitting the application form are provided on the next page. The application must be endorsed before submission.
- A successful applicant who requires further subsidy can be considered for the Special Assistance Fund from the National Council of Social Service using this same application.
- SG Enable will inform the Application Admin of the application outcome via email. Upon approval, the Application Admin must email the Invoice and Delivery Order to us before we proceed with the subsidy disbursement. The Invoice must show the full cost of the device(s). SG Enable will not accept reimbursement for devices already purchased.
- The designated Touchpoints are responsible for ensuring that prescribed and subsidized devices are received by the intended beneficiaries. If a proxy is appointed, the Touchpoints are required to verify the proxy's appointment and ensure the devices are collected on behalf of the intended beneficiary.

## IMPORTANT NOTES

- SG Enable reserves the right to reject any application that is incomplete, not supported with the required documents and/or arising from unauthorised Touchpoints.

## PROCESSING TIME

- Upon receipt of the completed application form and all required supporting documents, SG Enable requires up to 15 working days to process the application.

## SEND APPLICATION TO

- Registered Touchpoints' Application Admin/Assessor may submit applicant's ATF application online using your CorpPass via the eService portal.
- Unregistered Touchpoints must submit the completed application form and the Disability Verification Form (if required) to ATF@sgenable.sg.

SG ENABLE
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CONTACT US: Infoline: 1800 8585 885
Website: www.sgenable.sg

# APPLICATION FORM: ASSISTIVE TECHNOLOGY FUND

Updated as of Sep 2025
**(Please retain this page for your information)**

## ELIGIBILITY

- Singapore Citizen or Permanent Resident
- Have a permanent disability based on any one of the following:
    a. Physical Disability: Requires some assistance with at least 1 of the 6 Activities of Daily Living due to physical impairment
    b. Moderate visual impairment or worse in the better eye
    c. Moderate hearing loss or worse in the better ear
    d. Intellectual disability
    e. Autism

  Proof of disability must be provided using the Disability Verification Form (DVF) completed by a relevant registered Healthcare Professional.
- Undergone qualified assessor's assessment to determine the need and type of device(s)
- Household gross monthly income per person of $2,600 and below
- Annual Value (AV) of residence reflected on NRIC of $21,000 and below for households with no income.

**Note for Singaporean Seniors:**

Subject to eligibility,

a) Singaporean seniors who have not tapped on ATF before the age of 60 will be supported by the Seniors' Mobility and Enabling Fund (SMF). Please apply to SMF.

b) Singaporean seniors who have tapped on ATF before the age of 60 will be supported by ATF throughout their lifetime.

## SUPPORTING DOCUMENTS

Touchpoint's Application Admin will need to prepare the following documents to attach with the application:

☐ **SECTION 1:** APPLICANT AND HOUSEHOLD INFORMATION signed by the applicant or an authorised person if the applicant is below 21 years old/ mentally incapacitated.

☐ Clear photocopy of the applicant's NRIC (Front and Back) or Birth Certificate (for applicants below age 15).

☐ Clear photocopy of the authorised person's NRIC (Front and Back) for applicant who is below 21 years old/ mentally incapacitated.

☐ Valid Means-Test (MT) Result.

a. Household monthly income per person will be determined via the Household Means Eligibility System (HOMES). Applicants are advised to approach the Touchpoints (i.e. Public Hospitals and Social Service Agencies) for assistance with means testing. Please ensure means testing result has a minimum validity period of at least 3 months at the time of submission.

☐ **SECTION 2:** ASSESSOR'S REPORT is to be completed by a relevant registered Healthcare Professional and a qualified assessor indicating applicant's disability information (if required) and recommendation of device respectively.

b. Disability Verification Form (If required) to be completed by a relevant registered Healthcare Professional.

c. Assessor Report to be completed by qualified assessor stating clear recommendation of device(s).

☐ Vendor's quotation(s) to be provided by Touchpoint showing full cost of device(s).

d. We need to verify the device's cost. Please provide a formal quotation (preferred) or a memo/email from hospital/vendor, or price list, whichever is available.

☐ **SECTION 3:** APPLICATION ADMIN'S REPORT to be completed by Application Admin and Endorser.

e. Provide information such as the funding percentage requested for and reasons for requested subsidy level, applicant's other source of financial assistance and funding (if any) and subsidy disbursement details.

f. Application to be endorsed before submission to SG Enable.

## UPON APPLICATION APPROVAL

☐ Vendor's invoice(s) and delivery order to be provided by Touchpoint showing full cost of device(s).

g. Note: Email the invoice and the delivery order only after application approval to ATF@sgenable.sg. SG Enable will informTouchpoint of the application approval and request for the invoice and delivery order thereafter to facilitate subsidy disbursement.

Please tick ☑ where applicable.
*Please circle which applies.

# SECTION 1: APPLICANT AND HOUSEHOLD INFORMATION

## A. APPLICANT'S PARTICULARS

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

Identification Type: ◯ NRIC – Singapore Citizen, Permanent Resident ◯ Foreign Identification Number

Identification Number:

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

Age:

Citizenship: ◯ Singaporean ◯ Permanent Resident ◯ Others

Sex: ◯ Male ◯ Female

Preferred Spoken Language: ◯ English ◯ Mandarin ◯ Malay ◯ Tamil ◯ Others (please specify) _____

Contact (Mobile):

Contact (Home):

Contact (Office):

Email:

Address:

Postal Code: S

Unit No.: #  -

#0-0 if there is no unit no.

Preferred Contact Mode: ◯ Email ◯ Mail

Housing Type: ◯ HDB Flats (1 /2 /3 /4 /5 Room, Executive, Maisonette)* ◯ Private ◯ Others (please specify) _____

Present Occupation: ◯ Infant ◯ Student ◯ Working ◯ Training ◯ Unemployed ◯ National Service

## B. GUARDIAN INFORMATION

(For applicant below 21 years old and/or certified mentally incapacitated)

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

Identification Type: ◯ NRIC – Singapore Citizen, Permanent Resident ◯ Foreign Identification Number  Identification Number:

Relationship:

Guardianship: ◯ Legal Guardian ◯ Deputy ◯ Donee

Citizenship: ◯ Singaporean ◯ Permanent Resident ◯ Others

Date of Birth: (DD/MM/YYYY) / /  Sex: ◯ Male ◯ Female

Preferred Spoken Language: ◯ English ◯ Mandarin ◯ Malay ◯ Tamil ◯ Others (please specify) _____

Contact (Mobile):  Contact (Home):  Contact (Office):

Email: _____

Preferred Contact Mode: ◯ Email ◯ Mail

Stay With Applicant: ◯ Yes ◯ No

Address:

Postal Code: S  Unit No.: # - 

#0-0 if there is no unit no.

## C. DECLARATION

○ I do not want to receive mailers from and/or be contacted by SG Enable for related services and schemes in the future.

By using SG Enable services and by providing or making available my personal information or those of my ward and such other information about myself or my ward to SG Enable and/or MSF and continuing to do all of the above, I represent that:

1. 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 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.
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 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.

| Name of Applicant/ Authorised Person | Signature of Applicant/ Authorised Person | Date |
|---|---|---|

○ I consent on behalf of the Main Applicant who is under 21 years of age.

○ I consent on behalf of the Main Applicant who is mentally incapacitated.

This page is intentionally left blank.

## SECTION 2: ASSESSOR'S REPORT

Please tick ✓ where applicable.
*Please circle which applies.

This section is to be filled up by an Assessor. If this section is not filled up by a Therapist/ Optometrist/ Audiologist/ Medical Doctor, please give inputs in Part D: Others.

### A. APPLICANT'S PARTICULARS

PWD Name:

PWD Identification Number:

### B. DISABILITY INFORMATION

Please complete the attached Disability Verification Form in this application if the applicant's disability status has not been verified or they have a new disability condition which has not been verified previously.

The form must be completed by relevant Registered Healthcare Professionals from Public Hospitals or Social Service Agencies.

The applicants may check if their disability status have been verified by logging into SupportGoWhere with their Singpass: https://supportgowhere.life.gov.sg/grants/pwdr/apply

**Please note that a submitted Disability Verification Form (DVF) does not mean that your applicant's disability status has been verified.*

### C. DEVICE INFORMATION

Only Singaporean seniors with disabilities, who remain served by ATF, may claim for devices such as Oxygen Concentrator, Suction Pump and Spectacles.

Recommended device(s) should meet one or more of the outcomes listed below:

1. Aid in early intervention/ education
2. Aid in training
3. Aid in open/supported employment
4. Aid in therapy
5. Aid in rehabilitation
6. Increase independence in daily living

| No. | **Device Description** e.g. New Look Rodeo Tilt standard wheelchair with accessories or Oticon Chili SP5 BTE (left)/(right)/(both) | **Device Outcome** Choose outcome from the list above and check one or more that applies. | **Net Cost of Device (S$)** Including GST where applicable | **Vendor Name** | **Quotation Reference No.** If available |
|---|---|---|---|---|---|
| 1 | | ○ 1 ○ 3 ○ 5<br>○ 2 ○ 4 ○ 6 | | | |
| 2 | | ○ 1 ○ 3 ○ 5<br>○ 2 ○ 4 ○ 6 | | | |
| 3 | | ○ 1 ○ 3 ○ 5<br>○ 2 ○ 4 ○ 6 | | | |

## SECTION 2: ASSESSOR'S REPORT

Please tick ☑ where applicable.
*Please circle which applies.

### C. DEVICE INFORMATION (CONTINUED)

| No. | Device Description | Device Outcome | Net Cost of Device (S$) | Vendor Name | Quotation Reference No. |
|---|---|---|---|---|---|
| 4 | | ○ 1 ○ 3 ○ 5<br>○ 2 ○ 4 ○ 6 | | | |
| 5 | | ○ 1 ○ 3 ○ 5<br>○ 2 ○ 4 ○ 6 | | | |
| 6 | | ○ 1 ○ 3 ○ 5<br>○ 2 ○ 4 ○ 6 | | | |

Remarks (if any): _____

_____

(e.g. Elaborate how device will benefit applicant, justification of chosen AT, etc.)

Please provide quotation(s) for device(s) recommended. SG Enable may request Touchpoint to provide more quotes if required.

### D. OTHERS

Date of Assessment/ Recommendation: (DD/MM/YYYY) ☐☐/☐☐/☐☐☐☐

Are the Inputs to This Section Provided by a Therapist/Optometrist/Audiologist/ Medical Doctor? ○ Yes ○ No

If No, please state why in your view a therapist/doctor assessment was not necessary. e.g. Applicant is recommended a repair/ replacement/ upgrade of device. Please provide any medical documents stating permanence and type of disability.

_____

_____

_____

### E. SECTION COMPLETED BY

I confirm that the assessment done for the above applicant is true and correct to my best knowledge. I obtained consent from applicant for the assistive technology device(s) that are recommended to him. I am aware that the assessment for this application will serve as reference. SG Enable reserves the right to make the final decision on the application outcome and reject any application if the information is found to be inaccurate, or if any relevant information has been withheld by applicant.

Name: _____

Designation: _____

Email: _____

Contact No.: _____

_____ _____ _____

Signature | Date | Organisation Name

Please tick ☑ where applicable.
*Please circle which applies.

## SECTION 3: APPLICATION ADMIN'S REPORT

This section is to be filled in by Touchpoint's Staff and Endorser. Report need not be filled by a Social Worker/Medical Social Worker.

### A. APPLICANT'S PARTICULARS

PWD Name: _____

PWD Identification Number: _____

### B. APPLICATION ADMIN'S RECOMMENDATION

| | |
|---|---|
| 1 | Has Applicant been Means-Tested within the Past 2 Years? ◯ Yes ◯ No ◯ Unknown<br>If No, please assist applicant and household to complete Means-Test Declaration Form before proceeding with application. |
| 2 | Funding Percentage Requested for (%): _____<br>Please indicate % requested based on your assessment of the applicant's financial ability to co-pay<br>State the reasons if the funding percentage requested is higher than ATF qualified subsidy and if alternative co-payment modes such as installments or external funding can be explored.<br>_____<br>_____<br>_____ |
| 3 | Any Other Source of Subsidy Applied for this Recommended Device(s)? ◯ Yes ◯ No<br>_____<br>If Yes, please provide details on subsidy source(s). Double funding for the same device(s) is not allowed. |
| 4 | **For applicants 60 years and above**<br>Has subsidy been sought from other funds such as AIC SMF or HDB Ease for this device(s)? ◯ Yes ◯ No<br>_____<br>For Singaporean Seniors remaining with ATF, you may indicate as Nil.<br>For home retrofits, please provide details on subsidies sought/not sought. |
| 5 | Does Applicant Receive Financial Assistance?<br>◯ PA ◯ ComCare<br>◯ MFEC ◯ Others (please specify): _____<br>MediFund |

### C. ADDITIONAL INFORMATION

Additional Remarks (if any):

_____

_____

_____

Please attach other supporting documents if necessary

Please tick ✓ where applicable.
*Please circle which applies.

## SECTION 3: APPLICATION ADMIN'S REPORT

### D. APPROVED SUBSIDY DISBURSEMENT DETAILS

Both Touchpoints and Vendors are encouraged to register with us on the Enabling Services Management System (ESMS).

**Approved subsidy disbursement for Registered Touchpoints and Vendors will be made via GIRO.**

Disbursement Option (please select only one option): ◯ Touchpoint ◯ Vendor

Touchpoint will be kept informed of subsidy disbursement for all applications.

### E. APPLICATION ADMIN'S AND ENDORSER'S DECLARATION

By using the services offered by SG Enable and by providing or making available our personal information and such other information about us 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 SG 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 members 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 that 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.

## E. APPLICATION ADMIN'S AND ENDORSER'S DECLARATION (CONTINUED)

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, we agree to the above.

### Application Admin's Declaration

Application Admin Name: _____

Designation: _____

Email: _____

Contact (Mobile): _____ Contact (Office): _____

Organisation Address: _____

_____ _____ _____

Signature Date Organisation Name

### Endorser's Declaration

Endorser Name: _____

Designation: _____

Email: _____

Contact (Mobile): _____ Contact (Office): _____

_____ _____ _____

Signature Date Organisation Name

# DISABILITY VERIFICATION FORM (DVF)

## Important Notes

**The Disability Verification Form (DVF) verifies a person's disability status.** A person should get this form completed if they are applying for specific disability schemes under the Ministry of Social and Family Development (MSF).

**Instructions to the Person Needing Verification:**

- Persons who have previously enrolled in Special Education (SPED) schools and/or had their disability status verified when applying for eligible MSF disability schemes do **not** need to submit this form. Please check if you need to submit this form before proceeding. For more information on how to check your eligibility, please visit: enablingguide.sg/disability-verification.
- Please confirm the verification fees with the registered healthcare professional/clinic before proceeding, as fees may vary.

**Instructions to Healthcare Professionals (HCPs):**

- Ensure that all compulsory fields are completed, with any amendments endorsed by the HCP who completes this form. Failure to do so will result in the form being deemed incomplete and render this form void.
- A relevant HCP can complete this form. The relevant HCPs for each disability type are:
  1. **Physical Disability:**
     a. **Adults and Children 8 years and above:** Registered Doctor[1], Physiotherapist[2], Occupational Therapist[3], or Nurse[4].
     b. **Children below 8 years old[5]:** Registered Paediatrician.
  2. **Deafness/Hard-of-hearing:** Registered Ear, Nose, and Throat (ENT) Specialist or Audiologists registered with Society for Audiology Professionals Singapore (SAPS).
  3. **Visual Impairment**: Registered Ophthalmologist or Optometrist under full or conditional registration with the Optometrists and Opticians Board.
  4. **Intellectual Disability:** Registered Paediatrician, Psychiatrist, or Clinical/Educational Psychologist registered as members of Singapore Psychological Society (SPS) and Singapore Registry of Psychologists (SRP), and practising in public/private hospitals, social service agencies or private clinics.
  5. **Autism:** Registered Paediatrician, Psychiatrist, or Clinical/Educational Psychologist registered with SPS and SRP, and practising in public/private hospitals, social service agencies or private clinics.

**Please note:**

- Verification of disability status does not automatically qualify a person for disability schemes or services. Further scheme-specific criteria may apply.
- MSF and/or SG Enable reserve the right to make the final decision on the verification of disability status, and outcome of any application made.
- MSF and/or SG Enable may request further information for any investigations, checks or audits of this disability verification, disability schemes or other assistance schemes, and may make a police report or take legal action if any false information is provided in this application.

[1] Doctors with full or conditional registration issued by the Singapore Medical Council, and practising at the premises of a licensed healthcare institution under the Healthcare Services Act.

[2] Physiotherapists with full, conditional or restricted registration issued by the Allied Health Professions Council (AHPC).

[3] Occupational therapists with full, conditional or restricted registration (only "Physical dysfunction / Adults and older adults" classification) issued by AHPC.

[4] Registered nurses with full or conditional registration issued by the Singapore Nursing Board.

[5] Unless the child is bedridden, in which case 1(a) applies.

# DISABILITY VERIFICATION FORM (DVF)

| **Section A: Patient's Particulars**<br>**(To be completed by the Healthcare Professional only)**<br>All fields are compulsory. | |
|---|---|
| Name of Person Needing Verification: | NRIC/Birth Certificate No. of Person Needing Verification: |

| **Section B: Verification of Disability Type**<br>**(To be completed by the Healthcare Professional only)**<br>This field is compulsory. | |
|---|---|
| Verifying For<br>*(Tick all that apply)* | ☐ Physical Disability (Complete Section B1)<br>☐ Deafness / Hard-of-Hearing (Complete Section B2)<br>☐ Visual Impairment (Complete Section B3)<br>☐ Intellectual Disability (Complete Section B4)<br>☐ Autism (Complete Section B5) |

| **Section B1: Verification of Physical Disability**<br>**(To be completed by a Registered Doctor / Physiotherapist / Occupational Therapist / Nurse only)**<br>*Please refer to Circular No. 46/2025 for details on the verification of Physical Disability* | |
|---|---|
| **(1) Does the Person Needing Verification have a specified condition?**<br>*(Note: Please refer to Circular No. 46/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)*<br><br>**If yes,** please state the condition.<br>**If no,** please leave blank and go onto **(2)**. | **Specified Condition:**<br><br>_____<br><br>**Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY)<br><br>_____/_____ |

*Verification of Physical Disability continues on the next page*

## Section B1: Verification of Physical Disability

**(To be completed by a Registered Doctor / Physiotherapist / Occupational Therapist / Nurse only)**

*Please refer to Circular No. 46/2025 for details on the verification of Physical Disability*

**(2)** Please complete the ADL assessment below **only if the Person Needing Verification does not have a specified condition under (1) causing Physical Disability, or wishes to apply for MOH's ADL-based schemes:**

### Activities of Daily Living (ADLs)[6]

*Please complete the verification and ensure all six ADLs have been ticked accordingly.*
*If any of the ADLs are left blank, it will be taken that the Person Needing Verification is independent in performing the ADL.*

| | Requires help/supervision | Independent – No help is required |
|---|---|---|
| Mobility | ☐ | ☐ |
| Washing or Bathing | ☐ | ☐ |
| Dressing | ☐ | ☐ |
| Feeding | ☐ | ☐ |
| Toileting | ☐ | ☐ |
| Transferring | ☐ | ☐ |

**Please estimate when the Person Needing Verification first required assistance with the ADLs:**

_____/_____ (MM/YYYY)

**Indicate whether the need for assistance is required for 6 months or more from the date of assessment:**

☐ Yes, required for 6 months or more from the date of assessment
☐ No, required for less than 6 months

| | |
|---|---|
| **Impairment affecting ADLs** | If Person Needing Verification requires help/supervision with the ADLs, please indicate whether functional ability for the ADLs are predominantly affected by physical impairment, cognitive impairment, or both.<br>☐ Physical Impairment ☐ Cognitive Impairment<br>☐ Both Physical and Cognitive Impairment |

**If there is a known condition that gave rise to the need for assistance with ADLs, please state it here:**

---

[6] ***Activities of Daily Living (ADLs) are defined as follows:***

***Mobility:*** *Needs help to walk indoors or move in a wheelchair from room to room on level surface for about 8 metres (about twice the length of a clinic). This is regardless of the use of walking aid(s) and the speed of walking.*

***Washing or Bathing:*** *Needs help to wash body (excluding back) in the bath, shower or sponge / bed bath. Includes subcomponents of washing, rinsing and drying.*

***Dressing:*** *Needs help to put on, take off, secure and unfasten garments (upper and lower) and any braces, artificial limbs or other surgical appliances.*

***Feeding:*** *Needs help to feed oneself after food has been prepared and made available.*

***Toileting:*** *Needs help to use the toilet and manage bowel and bladder hygiene. Consists of (i) maintenance of balance during the act of urination or defecation and clothing adjustment, and (ii) maintaining perineal hygiene such as using toilet paper to clean the perineum. Independent of actual bowel or bowel functions e.g., incontinence. Does not include changing of long-term indwelling catheter.*

***Transferring:*** *Needs help to transfer from bed to an upright chair or wheelchair, and vice versa. Includes (i) sitting up from a lying position; (ii) moving from a sitting to standing position; (iii) a weight or pivot shift; and (iv) a controlled descent to a sitting position in another location.*

| **Section B2: Verification of Deafness / Hard-of-Hearing**<br>**(To be completed by a Registered ENT Specialist / Audiologist only)**<br>*Please refer to Circular No. 47/2025 for details on the verification of Deafness / Hard-of-hearing*<br>All fields are compulsory. | |
|---|---|
| **Unaided hearing threshold in better ear**<br>*(Note: Please refer to Circular No. 47/2025 for the thresholds.)* | ☐ No or better than mild hearing loss<br>☐ Mild*(Please refer to the circular)<br>☐ Moderate<br>☐ Moderate-Severe<br>☐ Severe<br>☐ Profound |
| **Is the hearing loss long-term** (i.e., will last 6 months or more from the date of the most recent assessment)? | ☐ Yes<br>☐ No |
| **Please estimate when the Person Needing Verification was first diagnosed with hearing loss** (MM/YYYY) | *Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with hearing loss.* |
| **If there is a known condition that gave rise to the hearing loss, please state it here:** | |

## Section B3: Verification of Visual Impairment

**(To be completed by a Registered Ophthalmologist / Optometrist only)**

*Please refer to Circular No. 48/2025 for details on the verification of Visual Impairment*

| | |
|---|---|
| **(1) Does the Person Needing Verification have a specified condition?**<br>*(Note: Please refer to Circular No. 48/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)*<br><br>**If yes,** please state the condition.<br>**If no,** please leave blank and go onto **(2)**. | **Specified Condition:**<br><br>_____<br><br>**Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY)<br><br>_____/_____ |

**(2)** Please complete the section below **only if the Person Needing Verification does not have a specified condition under (1) causing Visual Impairment:**

**Visual Assessment** / **Severity of Visual Impairment**:

*Please complete the verification and ensure all fields have been filled accordingly.*

| | |
|---|---|
| **Visual Acuity in better eye with best possible correction**<br>*(Note: Please refer to Circular No. 48/2025 for the thresholds.)* | ☐ No or mild visual impairment*(Please refer to the circular)<br>☐ Low vision<br>☐ Legally blind<br>☐ No light perception<br>☐ Not tested |
| **Visual field in better eye with best possible correction** | ☐ Visual field > 20 degrees<br>☐ 11-20 degrees<br>☐ ≤10 degrees<br>☐ Not tested |
| **Is the visual impairment long-term** (i.e., will last 6 months or more from the date of the most recent assessment)? | ☐ Yes<br>☐ No |
| **Please estimate when the Person Needing Verification was first diagnosed with visual impairment** (MM/YYYY) | *Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with visual impairment.* |

**If there is a known condition that gave rise to the visual impairment, please state it here:**

## Section B4: Verification of Intellectual Disability

**(To be completed by a Registered Paediatrician / Psychiatrist / Clinical or Educational Psychologist only)**

*Please refer to Circular No. 49/2025 for details on the verification of Intellectual Disability*

| | |
|---|---|
| **(1) Does the Person Needing Verification have a specified condition?**<br>*(Note: Please refer to Circular No. 49/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)*<br><br>**If yes,** please state the condition.<br>**If no,** please leave blank and go onto **(2)**. | **Specified Condition:**<br><br>_____<br><br>**Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY)<br><br>_____/_____ |

**(2)** Please complete the section below **only if the Person Needing Verification does not have a specified condition under (1) causing Intellectual Disability and has a <u>confirmed</u> clinical diagnosis of Intellectual Disability**[7]:

*Please complete the verification and ensure all fields have been filled accordingly.*

| | |
|---|---|
| **Severity of Intellectual Disability**[8] | ☐ Mild Intellectual Disability<br>☐ Moderate Intellectual Disability<br>☐ Severe Intellectual Disability<br>☐ Profound Intellectual Disability<br>☐ Severity not specified |
| **Please estimate when the Person Needing Verification was first diagnosed with Intellectual Disability** (MM/YYYY) | *Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with intellectual disability.* |

**If there is a known condition that gave rise to the Intellectual Disability, please state it here:**

[7] This should be a confirmed clinical diagnosis of intellectual disability that fulfils all criteria in the prevailing version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM; currently DSM-5) or the World Health Organisation's International Classification of Diseases (ICD; currently ICD-11).

[8] This should be completed based on the compositive severity (Intelligence Quotient (IQ) and Adaptive Functioning) if available; otherwise, it can be completed on the basis of IQ score.

## Section B5: Verification of Autism

**(To be completed by a Registered Paediatrician / Psychiatrist / Clinical or Educational Psychologist only)**
All fields are compulsory.
*Please refer to Circular No. 49/2025 for details on the verification of Autism*

Please complete the section below **only if the Person Needing Verification has a <u>confirmed</u> clinical diagnosis of Autism**[9]:
*Please complete the verification and ensure all fields have been filled accordingly.*

| | |
|---|---|
| **Level of Support Needs** | ☐ Level 1 (i.e., "Requiring Support")<br>☐ Level 2 (i.e., "Requiring Substantial Support")<br>☐ Level 3 (i.e., "Requiring Very Substantial Support")<br>☐ Level not specified |
| **Please estimate when the Person Needing Verification was first diagnosed with Autism** (MM/YYYY) | *Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with autism.* |

**If there is a known condition that gave rise to Autism, please state it here:**

[9] This should be a confirmed clinical diagnosis of autism that fulfils all criteria in the prevailing version of the DSM (currently DSM-5) or ICD (currently ICD-11), and in accordance with the diagnostic approaches recommended in the prevailing Clinical Practice Guidelines on Autism by the Academy of Medicine, Singapore. A confirmed clinical diagnosis of Asperger Syndrome will also be accepted. Clinicians should ensure additional supporting documents deemed necessary to verify a confirmed diagnosis are sighted.

## Section C: Healthcare Professional's Declaration and Signature

**Please tick one only:**

☐ The Person Needing Verification is **not related to me.**

☐ The Person Needing Verification **is related to me** or otherwise known to me outside my capacity as a registered healthcare professional. I declare that the Person Needing Verification is my family member or relative / friend / employer / employee / others* (please elaborate: _____).
**Please delete accordingly.*

**Declaration**

I have assessed the Person Needing Verification and confirm the information indicated in Sections A and B of this form are true and correct to the best of my knowledge.

**[For Doctors only]** I/My organisation also possess(es) the necessary licence(s) including the relevant and valid Healthcare Services Act (HCSA) licence(s) to conduct and submit the DVF.

**Compulsory field*

| Name of Healthcare Professional* | Registration No. of Healthcare Professional (where applicable) | Signature of Healthcare Professional* | Date of Completion of Form* |
|---|---|---|---|

| Contact Number of Healthcare Professional* | Email Address of Healthcare Professional | Institution Stamp* |
|---|---|---|