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 **(To be completed by the Healthcare Professional only)** All fields are compulsory.	
Name of Person Needing Verification:	NRIC/Birth Certificate No. of Person Needing Verification:

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

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*	
(1) Does the Person Needing Verification have a specified condition? *(Note: Please refer to Circular No. 46/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)* **If yes,** please state the condition. **If no,** please leave blank and go onto **(2)**.	**Specified Condition:** _____ **Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY) _____/_____

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. ☐ Physical Impairment ☐ Cognitive Impairment ☐ 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:

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[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 **(To be completed by a Registered ENT Specialist / Audiologist only)** *Please refer to Circular No. 47/2025 for details on the verification of Deafness / Hard-of-hearing* All fields are compulsory.	
Unaided hearing threshold in better ear *(Note: Please refer to Circular No. 47/2025 for the thresholds.)*	☐ No or better than mild hearing loss ☐ Mild*(Please refer to the circular) ☐ Moderate ☐ Moderate-Severe ☐ Severe ☐ Profound
Is the hearing loss long-term (i.e., will last 6 months or more from the date of the most recent assessment)?	☐ Yes ☐ 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? *(Note: Please refer to Circular No. 48/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)* **If yes,** please state the condition. **If no,** please leave blank and go onto **(2)**.	**Specified Condition:** _____ **Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY) _____/_____

(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 *(Note: Please refer to Circular No. 48/2025 for the thresholds.)*	☐ No or mild visual impairment*(Please refer to the circular) ☐ Low vision ☐ Legally blind ☐ No light perception ☐ Not tested
Visual field in better eye with best possible correction	☐ Visual field > 20 degrees ☐ 11-20 degrees ☐ ≤10 degrees ☐ 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 ☐ 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? *(Note: Please refer to Circular No. 49/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)* **If yes,** please state the condition. **If no,** please leave blank and go onto **(2)**.	**Specified Condition:** _____ **Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY) _____/_____

(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 ☐ Moderate Intellectual Disability ☐ Severe Intellectual Disability ☐ Profound Intellectual Disability ☐ 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") ☐ Level 2 (i.e., "Requiring Substantial Support") ☐ Level 3 (i.e., "Requiring Very Substantial Support") ☐ 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*