DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

The Disabled Persons Scheme is a means-tested scheme that supports Singapore Citizens with permanent physical disabilities who are unable to use public transport (i.e. bus and/or MRT) and require a vehicle to earn a living. Eligible drivers are exempted from paying the premium for the Certificate of Entitlement (COE) and the Additional Registration Fee (ARF) when they purchase a vehicle.

The application for the waiver of ARF and COE under the DPS will be considered by the DPS Committee comprising representatives from the Ministry of Social and Family Development (MSF), Land Transport Authority (LTA) and medical services.

ELIGIBILTY

Applicant must meet all of the following criteria:

- Singapore Citizen
- Persons with permanent physical disabilities who are medically certified by doctors from the Tan Tock Seng Hospital, Clinic for Advanced Rehabilitation Therapeutics (CART) as permanently disabled and incapable of taking public transport (i.e. bus and/or MRT), but fit to drive
- Gainfully employed and need a vehicle to earn a living
- Possess a valid Class 3 Driving Licence
- In the 30th income percentile or below where the household income does not exceed $6,500 for a 4-member household

To apply for the DPS, please submit the attached application form to SG Enable together with all the required supporting documents.

SG Enable reserves the right to reject any application that is incomplete or is not supported by the required documents specified.

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

(Please retain this page for your information)

TERMS AND CONDITIONS

SUCCESSFUL APPLICANTS MUST COMPLY WITH THE FOLLOWING TERMS AND CONDITIONS OF THE DPS:

A	Prior to registration of the car under the DPS, the applicant must de-register or transfer to another party any existing vehicle(s) under his/her ownership. The applicant is also not allowed to register or transfer any other vehicle(s) into his/her ownership during the period when he/she has a car registered under the DPS.
B	The applicant must personally drive and be in charge of the car at all times.
C	The applicant is only allowed to register a car that meets all of the following specifications: • Engine capacity must not be more than 1,600cc; and • Maximum power output of not more than 97kW (130bhp); and • Vehicle must have an Open Market Value (OMV) of not more than S$20,000
D	If the car needs to be modified to suit the applicant's disability, an approval letter from LTA must be obtained first. Thereafter, the applicant is required to produce the modified car for inspection at any of the authorised inspection centres. The modified car must pass the inspection before it can be registered. For advice on modifications to your car, please contact LTA's Vehicle Engineering Division at Tel: 6553 5794.
E	If the car does not require any modification, the applicant must give an undertaking to that effect.
F	The applicant can only sell the car after written approval from LTA is granted.
G	If the car is transferred to a person who is not eligible for the exemption, the applicant must pay LTA the relevant ARF, which is based on the applicable ARF rate multiplied by the car's OMV at the point when the car was registered. The new car buyer will also need to bid for a COE† in the appropriate vehicle category under the Vehicle Quota System.
H	The car registered under the DPS is not eligible for PARF benefit.
I	If any of the terms and conditions listed above are breached, the applicant will be required to pay the full ARF determined at the time of registration of the car and bid for a COE† in order for the car to remain registered.

† Criteria for COE obtained from the Feb 2014 first bidding exercise onwards:
Category A – Car with engine capacity up to 1,600cc and maximum power output up to 97kW (130bhp)
Category B – Car with engine capacity above 1,600cc or maximum power output above 97kW (130bhp)

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

(Please retain this page for your information)

The instructions for completing and submitting the application form are as below:

SUPPORTING DOCUMENTS:

- Coloured photocopy of Applicant's NRIC (Front and Back)
- Photocopy of Applicant's Driving Licence (Front and Back)
- Photocopies of NRICs, Passports (for foreigners), Birth Certificates (for children) and Student Passes of the applicant's immediate family members
- Married applicants must submit a photocopy of their Marriage Certificate / Divorce Paper / Separation Paper / Death Certificate of Spouse (where applicable)
- Documentary proof of income of Applicant and all immediate family members as follows:
    a. CPF Statements showing monthly contributions for the past 12 months; and
    b. Latest Notice of Income Tax Assessment; and
    c. Payslips for the past 6 months from the current employer
- Employer's Verification Form (Annex B)
- Medical Assessment Forms as follows:
    a. Medical Examination Form (Annex C); and
    b. Disability Verification Form (Annex D) completed by a relevant registered Healthcare Professional, if the applicant's disability status is not already verified*.

Before proceeding, all applicants are encouraged to check if your disability status has already been verified by logging into SupportGoWhere: https://supportgowhere.life.gov.sg/status/pwdr with your Singpass.

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

Tan Tock Seng Hospital
Clinic for Advanced Rehabilitation Therapeutics (CART)
7 Jalan Tan Tock Seng, Annex 2 Level 1
Singapore 308440
Tel: 6889 4580

For information on operating hours and medical examination charges, please contact Tan Tock Seng Hospital, Clinic for Advanced Rehabilitation Therapeutics (CART) at Tel: 6889 4580. Doctor consultation is strictly by appointment only.

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

IMPORTANT NOTES:

- The completed application form must be signed by the applicant.
- Please note that there will be no refund of any costs/fees incurred to apply for DPS.
- You can register your DPS vehicle only upon obtaining approval of your DPS application. Upon approval, the applicant must register the car within six months from the date of approval.
- If the applicant also wishes to apply for Excise Duty exemption for the car, please visit www.customs.gov.sg or contact Singapore Customs at:

  SINGAPORE CUSTOMS
  55 Newton Road
  #07-01 Revenue House Singapore 307987
  Tel: 6355 2000

APPLICATION SUBMISSION:

Please send the application to the following mailing address:

SG ENABLE
The Secretary for Committee to Recommend Waiver of ARF & COE under the DPS
20 Lengkok Bahru
#01-01, Singapore 159053

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

APPLICANT'S PARTICULARS:

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

Identification Type: ☒ Singapore Citizen

Identification Number: S

Citizenship: ☒ Singaporean

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

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Preferred Spoken Language: ☐ English ☐ Mandarin ☐ Malay ☐ Tamil ☐ Others Please Specify: _____

Contact (Mobile):

Contact (Home):

Contact (Office):

Home Address:

Postal Code: S

Unit No.:
#0-0 if there is no unit no.

Email: _____

Preferred Contact Method: ☐ Email ☐ Mail

EMPLOYMENT INFORMATION (APPLICANT):

Occupation:

Designation:

Name of Employer:

Address of Employer: _____

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

NATURE OF DISABILITY:

☒ Physical Disability Description of Condition: _____
(e.g. Limb Amputation, Muscular Dystrophy)

Nature of Impairment: ☐ Permanent ☐ Temporary

FAMILY PARTICULARS:

- Family refers to applicant's spouse, children, parents and parents-in-laws staying in the same household address as reflected in their NRICs.
- For both the applicant and his/her immediate family members, please attach
  - CPF Statements showing monthly contributions for the past 12 months
  - Latest Notice of Income Tax Assessment
  - Payslips for the past 6 months from the current employer
  - Photocopies of NRICs (coloured printout for applicant), Passports (for foreigners), Birth Certificates (for children) and Student Passes
  - Married applicants must submit a photocopy of their Marriage Certificate / Divorce Paper / Separation Paper / Death Certificate of Spouse (where applicable)

S/N	Name	Relationship to Applicant	Date of Birth	Occupation / Job Title	Gross Monthly Income	Contact No.
1						
2						
3						
4						
5						
6						
7						
8						
Household Gross Monthly Income:				**Number of immediate family members living with me:**		

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

NEW VEHICLE PURCHASE INFORMATION - VEHICLE DETAILS:

Make:

Model:

Engine Capacity:

(must not exceed 1,600cc)

Maximum Power Output:

[must not exceed 97kW(130bhp)]

Modification: ☐ Yes ☐ No

Open Market Value (OMV):

(must not exceed $20,000)

CURRENT TRANSPORTATION DETAILS:

Current Mode of transportation: ☐ Car ☐ Bus ☐ MRT ☐ Taxi ☐ Others Please Specify:

Average Daily Transportation Expenditure:

Driving Licence No.:

Class: ☐ Class 2B ☐ Class 2A ☐ Class 2 ☐ Class 3
☐ Class 3A ☐ Class 4 ☐ Class 4A ☐ Class 5

EXISTING VEHICLE OWNERSHIP INFORMATION:

I own the following vehicle at the moment:

Vehicle No.:

Registration Date: (DD/MM/YYYY) : / /

Is the vehicle owned under DPS: ☐ Yes ☐ No

Reasons for replacing vehicle: _____

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

DECLARATION AND CONSENT:

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

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 www.sgenable.sg,as well as MSF's Privacy Statement, which can be found on its website at www.msf.gov.sg.
3. 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.
4. 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 has 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.
5. I shall personally drive and be in charge of my DPS car at all times and shall not allow anyone else to drive my car.
6. I declare that the information given above as well as the attached documents (if any) are true and correct. I am aware that it is a serious offence to provide false information and/or wilfully suppress any information in relation to this application, which, as a result, will render my application invalid and the waiver, if given, revoked. In such an event, I will be required to pay the full ARF determined at the time of registration and bid for a COE for my car to remain registered.
7. I undertake to register a car as approved by the Committee to Recommend Waiver of ARF and COE under the DPS within 6 months commencing from the date of approval.
8. I undertake to be solely responsible for my DPS car and will not compromise on safety should I decide not to modify my DPS car.

Signature of Applicant

Date

DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

Annex B (Page 1 of 1)

Please tick ☑ where applicable
*Please circle which applies

Date: _____

To: The Secretary for Committee to Recommend Waiver of ARF & COE under the DPS
20 Lengkok Bahru, #01-01, Singapore 159053

Dear Sir

APPLICATION FOR WAIVER OF ADDITIONAL REGISTRATION FEE (ARF) AND CERTIFICATE OF ENTITLEMENT (COE) UNDER THE DISABLED PERSONS SCHEME (DPS)

I wish to confirm that Mr/Mrs/Mdm/Ms/Miss* _____
(Name)

of _____ is employed by my company as _____
(NRIC No) (Occupation)

with effect from _____. He/She* is drawing a gross monthly salary
(Date)

of $_____.

Yours faithfully

_____
Signature and Company Stamp

Name: _____

Designation: _____

Email: _____

Telephone No.: _____
(for clarification)

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DISABLED PERSONS SCHEME (DPS) APPLICATION FORM

Annex C (Page 1 of 1)

Please tick ☑ where applicable
*Please circle which applies

To: The Secretary for Committee to Recommend Waiver of ARF & COE under the DPS
20 Lengkok Bahru, #01-01, Singapore 159053

Dear Sir / Madam,

WAIVER OF ADDITIONAL REGISTRATION FEE (ARF) AND CERTIFICATE OF ENTITLEMENT (COE) UNDER THE DISABLED PERSONS SCHEME (DPS)

1. I have examined Mr/Mrs/Mdm/Ms/Miss* _____
(Name)
of NRIC No.:
S | | | | | | | | |
Address: _____
_____
_____
Telephone No.: _____ on _____
(DD/MM/YY)

2. The nature of disablity is: _____
_____
_____

3. I certify that he/she* is:
◯ capable of travelling by bus/MRT
◯ incapable of travelling by bus/MRT
◯ severely disabled and unable to drive any motor vehicle
◯ physically disabled/permanently* confined to a wheelchair

4. Comments (if any): _____
_____
_____

_____ _____
Name & Signature Date
Consultant Physician (Rehabilitation Medicine)
Dept of Rehabilitation Medicine
Tan Tock Seng Hospital

5. Consent

I, _____ NRIC No. _____ agree to have my medical findings revealed to the relevant authorities for the purpose of my application for waiver of ARF and COE under the DPS.

_____	_____	_____
Name of Applicant	Signature of Applicant	Date
_____	_____	_____
Name of Witness	Signature of Witness	Date

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.

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:

---

[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*