SG ENABLE
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# APPLICATION FOR TAXI SUBSIDY SCHEME (TSS)

**The Taxi Subsidy Scheme supports persons with disabilities who are medically certified as unable to take public transport (i.e. bus/MRT) and totally dependent on taxis for travel to school, work or employment-related training supported by SG Enable.**

Visit https://www.enablingguide.sg/ → I'm Looking For Disability Support → Transport → Taxis and private hire cars → Taxi Subsidy Scheme (TSS) for more information.

## ELIGIBILITY CRITERIA

1. Singapore Citizens or Permanent Residents
2. 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. Intellectual disability
   d. Autism

   Proof of disability must be provided using the Disability Verification Form (DVF) completed by a relevant registered Healthcare Professional.
3. A working adult / student / trainee
   a. Adults who are in employment or have been accepted for employment
   b. Students attending mainstream schools or Institutes of Higher Learning (e.g. Polytechnics, ITEs and Universities) that are registered, approved or recognised by the Ministry of Education (MOE)
   c. Students attending private educational institutes registered with MOE or with the Council for Private Education (CPE) with a minimum course duration of two months
   d. Trainees attending employment-related training supported by SG Enable

   **Note:** Persons with disabilities who are in special education (SPED) schools or sheltered workshops may apply for the Enabling Transport Scheme (ETS).
4. Medically certified as unable to take public transport (i.e. bus/MRT) and totally dependent on taxis for travelling to school, work or employment-related training supported by SG Enable
5. Have a per capita household income (PCHI) of $3,600 per month or below
6. Do not own any motor vehicles

## REQUIRED DOCUMENTS

1. Copy of the **Applicant's NRIC** (Front and Back) or **Birth Certificate** (where applicable)
2. For Applicant < 21 years old
   Copy of **Parent / Guardian's NRIC** (Front and Back)
3. Copy of **Bank Book / Bank Statement** showing the bank name, account number and account payee name in full
4. Completed **Means Test Declaration Form**
   **Note:** You do not need to submit if you have been means tested within the past one year. If you are unsure on the validity of your means test, please complete a new form.
5. Completed **Travel Purpose Verification** (Part 2 of Application Form)
   **Note:** Please request the school / employer / training provider to provide the required details applicable to you.
6. Completed **Medical Assessment Report** (Part 3 of Application Form)
   **Note:** Please request a Singapore-registered Healthcare Professional from Public Hospitals or Social Service Agencies to complete the relevant sections in the report that is applicable to you depending on your disability condition.
7. Completed **Disability Verification Form (DVF)**
   **Note**: To be completed by a relevant registered Healthcare Professional for applicants:
   - whose disability status has not been verified, or
   - who has a new disability condition which have not been verified previously.

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

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

**IMPORTANT NOTES:**

This application form contains **THREE (3)** parts. **ALL THREE (3)** parts must be completed.

- **Part 1 – Application Form (To be completed by the Applicant)**
- **Part 2 – Travel Purpose Verification (To be completed by School / Employer / Training Provider)**
- **Part 3 – Medical Assessment Report (To be completed by a Singapore-registered Healthcare Professional from Public Hospitals or Social Service Agencies)**
- **Disability Verification Form (DVF) – To be completed by a relevant registered Healthcare Professional**

If you do not have a valid means test or your means test is expiring in one year's time, please complete and submit the Means Test Declaration Form with all the relevant supporting documents.

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# APPLICATION FOR TAXI SUBSIDY SCHEME (TSS)

**PART 1** **(Page 1 of 2)**

## A. APPLICANT'S PARTICULARS

Name:
(as in NRIC)

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

Identification Number:

Postal Code:
(as in NRIC) S

Unit Number: # - 
*(#0-0 if there is no unit number)*

Contact Number:

Email: _____

## B. PARENT / GUARDIAN'S INFORMATION *(FOR APPLICANTS BELOW 21 YEARS OLD)*

Name:
(as in NRIC)

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

Identification Number:

Relationship:

Contact Number:

Postal Code:
(as in NRIC) S

Unit Number: # - 
*(#0-0 if there is no unit number)*

Email: _____

## C. BANK DETAILS

Bank Account Payee Name:

Bank Account Number:

Bank Name:

Bank Code:

Branch Code:

☐ I hereby consent to and authorise SG Enable to disburse all approved taxi subsidies to the above third party bank account provided by me. (Please tick if applicant is not the account payee in the above bank account provided.)

## D. 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 number, contact number, mailing and email addresses 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 am aware that SG Enable has the right to recover in partial or in full any subsidy disbursed to me arising from this application if I have provided false or inaccurate information, or withheld or omitted any relevant information that is required.

4 I hereby consent to and authorise the Central Provident Fund Board to disclose to the Ministry of Social and Family Development and SG Enable my employment/self-employment status and employer contribution status as well as any other relevant information.

5 I give my consent for SG Enable to share the information provided above with EZ-Link and other relevant agencies, obtain my enrollment status or proof of educational certification from the Ministry of Education, Council for Private Education or the relevant education institutions, obtain information on my vehicle ownership from the Land Transport Authority, and my taxi transaction details from EZ-Link for the purposes of my application for the taxi subsidy scheme for persons with disabilities and/or the administration and provision of services and schemes to me, and/or data analysis, evaluation and policy formulation.

6 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.

7 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. I also consent to SG Enable to obtain information from the medical professional from whom the I have consulted or any parties deemed related for the purposes of verifying the eligibility status of the Applicant, and I authorise the medical professional/ related parties to release such information to SG Enable.

8 I agree that SG Enable is merely providing a platform to allow me to obtain service from third parties for no commercial gain or profit and as such there is no intention to create a legally binding agreement between myself and SG Enable and therefore, I further acknowledge and agree that SG Enable is not responsible for (a) any breaches, misfeasance or failure to discharge any duty of care or obligations on the part of any third parties contracting with me and (b) any claims for injuries, illnesses, damages, liabilities and costs ("liabilities") that I may suffer, directly or indirectly, in full or in part as a result of the acts or omissions of such third parties or anything in relation to any contract or transactions I may enter into with such third parties.

9 To the fullest extent permitted by law, I agree to and hereby waive and release SG Enable, its principals, subsidiaries, affiliates partners, officers, directors, staff members and agents from any liabilities arising from or related to (i) any breaches, misfeasance or failure to discharge any duty of care or obligations on the part of any third parties contracting with me and/or (ii) any indirect, special, punitive, consequential or incidental damages, whether based on a claim or action of contract, warranty, negligence, strict liability, or other tort, breach of any statutory duty, indemnity or contribution, or otherwise, even if SG Enable has been advised of the possibility of such damages.

| Name of Applicant / Parent / Guardian | Signature of Applicant / Parent / Guardian | Date |
|---|---|---|

*(NB: If Applicant is below 21 years old, this part is to be completed by the Parent / Guardian as listed under Section B)*

**IMPORTANT: THE EXPECTED PROCESSING TIME IS APPROXIMATELY 15 WORK DAYS UPON COMPLETE SUBMISSION. THE TSS CARD WILL BE SENT OUT WITHIN 2-4 WEEKS UPON FINAL APPROVAL. (NOTE: ISSUANCE OF THE TSS CARD IS ONLY APPLICABLE TO APPROVED APPLICANTS UTILISING THE TAXI SUBSIDY SCHEME FOR SCHOOL AND/OR WORK.)**

| | | |
|---|---|---|
| **SUBMISSION:** |  | Complete this application form and email together with the supporting documents **(in one attachment)** to tss@sgenable.sg |

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# APPLICATION FOR TAXI SUBSIDY SCHEME (TSS)

**PART 2** (Page 1 of 1)

## TRAVEL PURPOSE VERIFICATION

(To be completed by School / Employer / Training Provider)

### E. PURPOSE OF TRAVEL *(PLEASE SELECT ONE OF THE FOLLOWING)*

| | | | | | |
|---|---|---|---|---|---|
| ☐ | **SCHOOL** | ☐ | **WORK** | ☐ | **EMPLOYMENT-RELATED TRAINING supported by SG Enable** |

### F. APPLICANT'S PARTICULARS

Name:
(as in NRIC)

Identification Number:

### G. VERIFICATION *(TO BE COMPLETED BY AUTHORISED REPRESENTATIVE)*

Name of School / Employer / Training Provider:

Postal Code: S

Unit Number: # - 

*(#0-0 if there is no unit number)*

Start Date: (DD/MM/YYYY)

End Date: (DD/MM/YYYY)

Job Title / Course Name:

Employment Term:
(for working applicants only) ☐ Permanent ☐ Contract / Temporary

### H. DECLARATION *(TO BE COMPLETED BY AUTHORISED REPRESENTATIVE)*

I declare that the information given above is true and correct.

| Name of Authorised Representative | Designation of Authorised Representative | Signature of Authorised Representative |
|---|---|---|
| Contact Number | Email | Date |

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# APPLICATION FOR TAXI SUBSIDY SCHEME (TSS)

**PART 3** **(Page 1 of 2)**

## MEDICAL ASSESSMENT REPORT

### IMPORTANT NOTES

**Medical Assessment Report**

- To be completed by a Singapore-registered Healthcare professional from Public Hospitals or Social Service Agencies.
- The Assessing Healthcare Professional must complete all relevant fields and countersign against any amendments and /or ambiguity made on the medical assessment report. Failure to do so will deem the report as incomplete.
- The TSS medical assessment report is valid only for this application.

**Disability Verification Form (DVF)**

- Relevant registered Healthcare Professionals to also complete the Disability Verification Form (DVF) for patient:
  - whose disability status has not been verified, or
  - who has a new disability condition which has not been verified previously.
- Before proceeding, all applicants are encouraged to check if their disability status has already been verified by logging into SupportGoWhere with their Singpass: https://supportgowhere.life.gov.sg/grants/pwdr/apply .
- The Disability Verification Form (DVF) submitted needs to be completed by a relevant registered Healthcare Professional.

There will be no refund of any costs / fees incurred to apply for the scheme. Applicants are advised to look through the eligibility criteria of the scheme before proceeding with the medical assessment.

### I. PATIENT'S PARTICULARS

| | |
|---|---|
| Name: (as in NRIC) | |
| Date of Birth: (DD/MM/YYYY) | / / |
| Identification Number: | |

### J. FOR PATIENTS WITH PHYSICAL DISABILITY

**(To be completed by a Singapore-registered Doctor / Allied Health-registered Physiotherapist or Occupational Therapist only)**

**Notes for Assessing Healthcare Professional:** Mobility refers to the ability to walk indoors from room to room on level surface, without the use of assistive devices such as walking frame, walking stick, brace, cane, crutch, prosthetic device, or assistance of another person. To also take into account the patient's restriction to walk due to medical conditions such as lung, cardiac, arthritic, neurological, or orthopaedic condition and the use of oxygen.

| | | | | | | |
|---|---|---|---|---|---|---|
| a. Mobility Status: | ☐ | Requires help / supervision most of the time | | | ☐ | Independent |
| b. Dependency on taxi / dedicated transport: | ☐ | Permanent | ☐ | Temporary (≤ 6 months) | ☐ | Independent |

**FOR PATIENTS WHO DO NOT USE A WHEELCHAIR TO TRAVEL TO SCHOOL / WORK / TRAINING**

| | | | | |
|---|---|---|---|---|
| c. The patient is able to walk with a gait speed of more than or equal to 0.8m/second in a 10m walk test. | ☐ | Yes | ☐ | No |

**FOR PATIENTS WHO USE A WHEELCHAIR TO TRAVEL TO SCHOOL / WORK / TRAINING**

| | | | | |
|---|---|---|---|---|
| d. The patient is able to safely and independently proper him/herself into an out of the clinic, including manoeuvring corners and inclination. | ☐ | Yes | ☐ | No |

e. Additional comments (if any):

## K. FOR PATIENTS WITH VISUAL IMPAIRMENT

| | | | | |
|---|---|---|---|---|
| a. Is the patient diagnosed with total / legal blindness? | ☐ | Yes | ☐ | No |
| b. **If (a) is no,** does the patient have any mobility issues that make it difficult for him/her to take public transport safely? | ☐ | Yes | ☐ | No |
| c. Nature of mobility issues: | ☐ | Permanent | ☐ | Temporary (≤ 6 months) |

d. Please state the mobility issues:

e. Additional comments (if any):

## L. FOR PATIENTS WITH INTELLECTUAL DISABILITY / AUTISM

**Notes for Assessing Healthcare Professional:** Challenging behaviour refers to culturally abnormal behaviour of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit the use of, or result in the person being denied access to, ordinary community facilities.

| | | | | |
|---|---|---|---|---|
| a. Does the patient have any challenging behaviours that make it difficult for him/her to take public transport safely? | ☐ | Yes | ☐ | No |
| b. Nature of challenging behaviours: | ☐ | Permanent | ☐ | Temporary (≤ 6 months) |

c. Please state the challenging behaviours:

d. Additional comments (if any):

## M. CONFIRMATION OF ASSESSMENT BY ASSESSING HEALTHCARE PROFESSIONAL

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

I confirm that the assessment done for the above patient is true and correct. 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 the patient.

| | | |
|---|---|---|
| Name of Assessing Healthcare Professional | Signature of Assessing Healthcare Professional | MCR/AHPC No. of Assessing Healthcare Professional |
| Clinic/Hospital Stamp | Contact Number | Date of Assessment |

# 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* |
|---|---|---|