



# Means-Test Declaration Form

This form is used for patients/ clients to undergo household means-testing<sup>1</sup> for the purpose of application for various government subsidy schemes (see descriptions below). Besides means-testing, patients/ clients will still need to meet all other eligibility criteria to qualify for any schemes. Patients/ clients do not need to complete this form if they have already been means-tested through any of these schemes in the past two years.

**Eldercare and Disability Subsidies:** MSF subsidies are open to Singapore Citizens and Permanent Residents in MSF-funded Eldercare/ Disability Institutions. Applicants will be assessed for their medical and/ or social needs before admission.

**MSF Taxi Subsidy Scheme (TSS):** The TSS supports eligible Singapore Citizens and Permanent Residents with permanent disabilities who are medically certified as unable to take public transport and are totally dependent on taxis for travelling to school, work, and/or employment-related training supported by SG Enable.

**MSF VVO Transport Subsidy Scheme (VWOTS):** The VWOTS supports eligible Singapore Citizens and Permanent Residents with disabilities who need to use dedicated transport provided by the Social Service Agencies (SSAs) to access the Early Intervention Programme for Infants and Children (EIPIC), Special Education (SPED) schools, Day Activity Centres (DACs), Sheltered Workshops (SWs) and Special Student Care Centres (SSCCs).

Applicants may wish to refer to SG Enable's website (<https://www.sgenable.sg>) for details of the eligibility criteria and frequently asked questions for the two schemes.

<sup>1</sup> Household information shall include information for all family members living at the same residence, as reflected on the NRIC address. Family members shall refer to persons related by blood, marriage and/ or legal adoption (includes parents, spouse, children, siblings, grandchildren, and children-in-law e.g. daughter/ son-in-law, and excludes foster child). Please note that the information provided in this form may result in an update to your Medishield Life Premium Subsidies eligibility information.

<sup>^</sup> **Household monthly income per person** is the total gross household monthly income divided by total number of family members living together. Gross monthly household income refers to your basic employment income, trade/ self-employed income, overtime pay, allowances, cash awards, commissions, and bonuses.

Income for salaried employees will be the monthly income averaged over 12 months as derived by the Central Provident Fund (CPF) Board with the latest available information, or based on the latest available assessment by the Inland Revenue Authority of Singapore (IRAS) within the last 2 calendar years.

Income for self-employed persons will be the monthly income averaged over 12 months based on the latest available assessment by IRAS within the last 2 calendar years, or the income declared to the CPF Board or assumed under the CPF legislation.

Income for non-SC/ PR household members will be the monthly income averaged over 12 months based on the latest available assessment by IRAS within the last 2 calendar years, or the latest income declared to the Ministry of Manpower (MOM).

<sup>^^</sup> **AV** is the estimated annual rent of your residence (as reflected on your NRIC) if it is rented out.

**To undergo means-testing for any of the above schemes:**

1. Complete this declaration form in full, ensuring that:
  - The Main Applicant and all Household Members aged 21 and above have signed or given thumbprint on page 7 to verify the details and grant consent for means-testing, unless exempted from providing consent under the conditions stated on page 8;
  - For a Main Applicant and any Household Member(s) below 21 years old, the Parent or Legal Guardian has signed or given thumbprint as consent/ declaration on behalf of him/ her.
2. Attach clear photocopies (front and back) of the NRIC/ FIN+ for Main Applicant and all Household Members.
3. For individuals who are Singapore Citizens or Singapore Permanent Residents with overseas employment and/ or trade income (i.e. a salaried employee and/ or self-employed personnel overseas), please indicate your gross monthly income within the form and attach pay slips, employment letter or any income documents of the latest month as verification. If the gross monthly income changes every month, please submit that of the latest 3 months.
4. For foreigners and Special Pass holders:
  - Please submit supporting document(s) to prove relationship to Main Applicant or Household Member living at the same address (e.g. marriage certificate, birth certificate); and
  - Please indicate your gross monthly income within the form and attach pay slips, employment letter or any income documents of the latest month as verification. If the gross monthly income changes every month, please submit that of the latest 3 months.
5. Submit the completed form<sup>++</sup> and all other supporting documents to:

**Harbourfront Centre Post Office, P.O. Box 074, Singapore 910932**

<sup>+</sup> For persons below age 15 or who are Special Pass holders, please include a photocopy of the person's Birth Certificate or Special Pass where relevant.

<sup>++</sup> Any incomplete forms lacking consent signatures/ thumbprint and/ or other supporting documents will be sent back to the applicants for completion.







**Definitions**

1. Throughout this form, the words and expressions below shall have the meanings hereby ascribed to them.
- 2.1 **“Cooperating Parties”** shall refer to the Government of the Republic of Singapore (the **“Government”**), and such statutory boards and organisations as approved by the Government that are involved in or assisting in the provision and delivery of the Services and Schemes.
- 2.2 **“Family Member”** means a person related to the Main Applicant by blood, marriage and/ or legal adoption.
- 2.3 **“Personal Information”** means an individual’s personal data (e.g. name, NRIC No, address, age, gender, family/ household structure), financial data (e.g. income, savings, insurance coverage), consumption data (e.g. payment for utilities, housing, healthcare bills, scheme participation), social assistance data (e.g. social assistance history, assessments for eligibility and suitability for various Services and Schemes, social worker case reports) or medical information, that is relevant for the Purpose (as defined in paragraph 4 below).
- 2.4 **“Services and Schemes”** means public services and schemes, which include the following:
  - (a) aged care, childcare, education, healthcare, social assistance and counselling services and schemes;
  - (b) any form of financial assistance such as subsidies, grants, tax reliefs, vouchers or bursaries; and
  - (c) retirement, savings and insurance schemes operated by Government, CPF Board or their appointed agents.

**Consent**

3. I understand that the sharing of personal information between different entities such as the Government, and certain statutory boards, and organisations as approved by the Government will assist in the evaluation of my and/ or my Family Members’ suitability and eligibility for certain healthcare, social and other public services and schemes.
4. Subject to paragraph 5, by signing this consent, I agree that any Cooperating Party may:
  - (a) collect my Personal Information from me or any of the other Cooperating Parties;
  - (b) disclose my Personal Information to any of the other Cooperating Parties; and
  - (c) use my Personal Information,regardless of whether my Personal Information relates to matters occurring before, on or after the date of this consent, for the purposes of:
  - (i) evaluating my and/ or my Family Members’ suitability and eligibility for the Services and Schemes at any time;
  - (ii) the administration and provision of the Services and Schemes in relation to me and/ or my Family Members; and/ or
  - (iii) data analysis, evaluation and policy formulation, in which I and/ or my family members shall not be identified as specific individuals or households(collectively known as the **“Purpose”**).
5. I consent to the Inland Revenue Authority of Singapore (IRAS) and the Central Provident Fund Board (CPF Board) disclosing to the Cooperating Parties the following information (hereinafter referred to as the **“IRAS and CPF Information”**):
  - (a) my income information;
  - (b) information relating to my CPF contributions and any information that may be derived therefrom;
  - (c) information relating to my CPF Accounts (e.g. account balance, withdrawal details, etc.);
  - (d) information relating to or arising from my participation in schemes administered by the CPF Board (e.g. medical information, insurance coverage, etc.),whether such IRAS and CPF Information relates to matters occurring before, on or after the date of this consent, necessary or the purposes of means-testing or otherwise determining my or any of my Family Members’ access or eligibility to any subsidies, financial assistance or other social assistance programmes or schemes, as and when required from time to time. For the avoidance of doubt, the IRAS and CPF Information shall not include such information obtained by CPF Board in the course of conducting surveys.
6. I understand that this consent shall remain in effect unless revoked in writing. I accept that the withdrawal of consent will only take effect within 7 working days from the date of receipt of the withdrawal.
7. This consent shall be governed by and construed in accordance with the laws of the Republic of Singapore.

**Declaration**

8. I declare that I am the Main Applicant, a Family Member of, and living at the same residential address as, the Main Applicant, or an individual authorised to provide consent on behalf of the Main Applicant/ Family Member living at the same residential address.
9. Where I am providing consent on behalf of the Main Applicant/ Family Member(s) who is under 21 years of age, I further declare that I am his/ her parent/ legal guardian.
10. Where I am providing consent on behalf of the Main Applicant/ Family Member(s) who is mentally incapacitated, I further declare that I am:
  - (a) his/ her appointed donee(s) acting under a Lasting Power of Attorney granted by the Main Applicant/ Family Member under the Mental Capacity Act (Cap. 177A) when he/ she was above 21 years old, or
  - (b) his/ her deputy(s) appointed by the Court under the Mental Capacity Act (Cap. 177A) to act on behalf of the Main Applicant/ Family Member.
11. I declare that all the information provided by me in this form is true, correct and accurate.
12. I understand and acknowledge that if any of the information provided by me in this form is false or inaccurate, I and/ or my Family Members will be liable to repay in full the value of any assistance granted, inclusive of all administrative expenses, and also may face criminal prosecution.

**Section C**

**Consent/ Declaration**

**Main Applicant's Name:**

**Signature/ Thumbprint (Date):**

**Name of signatory (Where consent is provided on behalf of the Main Applicant)\*\*:**

I hereby confirm that I understand and agree to all the provisions in this form.

\*\* Tick one of the following, where applicable:

I am the parent/ legal guardian and have consented on behalf of the Main Applicant who is under 21 years of age<sup>1</sup>

I/ We have consented on behalf of the Main Applicant who is mentally incapacitated<sup>2</sup>

**Family Member's Name:**

**Signature/ Thumbprint (Date):**

**Name of signatory (Where consent is provided on behalf of the Family Member)\*\*:**

\*\*Tick one of the following, where applicable:

I am the parent/ legal guardian and have consented on behalf of the Family Member who is under 21 years of age<sup>1</sup>

I/ We have consented on behalf of the Family Member who is mentally incapacitated<sup>2</sup>

I hereby confirm that I understand and agree to all the provisions in this form.

**Family Member's Name:**

**Signature/ Thumbprint (Date):**

**Name of signatory (Where consent is provided on behalf of the Family Member)\*\*:**

\*\*Tick one of the following, where applicable:

I am the parent/ legal guardian and have consented on behalf of the Family Member who is under 21 years of age<sup>1</sup>

I/ We have consented on behalf of the Family Member who is mentally incapacitated<sup>2</sup>

I hereby confirm that I understand and agree to all the provisions in this form.

**Family Member's Name:**

**Signature/ Thumbprint (Date):**

**Name of signatory (Where consent is provided on behalf of the Family Member)\*\*:**

\*\*Tick one of the following, where applicable:

I am the parent/ legal guardian and have consented on behalf of the Family Member who is under 21 years of age<sup>1</sup>

I/ We have consented on behalf of the Family Member who is mentally incapacitated<sup>2</sup>

I hereby confirm that I understand and agree to all the provisions in this form.

**Family Member's Name:**

**Signature/ Thumbprint (Date):**

**Name of signatory (Where consent is provided on behalf of the Family Member)\*\*:**

\*\*Tick one of the following, where applicable:

I am the parent/ legal guardian and have consented on behalf of the Family Member who is under 21 years of age<sup>1</sup>

I/ We have consented on behalf of the Family Member who is mentally incapacitated<sup>2</sup>

I hereby confirm that I understand and agree to all the provisions in this form.

**Instructions to Main Applicant/ Family Member(s):**

- 1 Please provide a copy of the signatory's NRIC/ Passport if he/ she is not the Main Applicant/ Family Member listed in this application. Note that the signatory has to be the parent/ legal guardian.
- 2 Please check whether the donee/ deputy may act singly or has to act jointly with other donee(s)/ deputy(s). If the donees/ deputies are required to act jointly, all donees/ deputies must provide consent on behalf of the Main Applicant/ Family Member. Please provide a copy of the Lasting Power of Attorney/ Order of Court and NRIC/ Passport of the donee(s)/ deputy(s) if he/ she is not the Main Applicant/ Family Member listed in this application.

**Note:**

- For Main Applicant/ Family Member(s) who is unable to provide consent, please complete the section "**Unable to Provide Consent or Consent On Behalf**" in this form.
- If one or more of the above signatories does/ do not read English, the name of the interpreter is \_\_\_\_\_ (name).

### Unable to Provide Consent or Consent On Behalf

The following Main Applicant/ Family Member (aged 21 and above) is unable to provide consent:

Name (as in NRIC): \_\_\_\_\_

**Reason for Inability to Provide Consent or Consent On Behalf (tick one of the following)<sup>1</sup>:**

- Mentally incapacitated but a donee has not been appointed under a Lasting Power of Attorney or deputy has not been appointed by the Court under the Mental Capacity Act (Cap. 177A)<sup>2</sup>  
(please fill in doctor's certification below)
- In prison
- Overseas
- Others (please specify) \_\_\_\_\_

**Note:**

- You may be contacted subsequently to provide additional supporting documents or information for verification purposes.
- This does not apply to a family member who is mentally incapacitated but has an appointed donee/ deputy - the donee/ deputy can give consent on behalf of the family member on page 7, and a doctor's certification is not required.

### Doctor's Certification for Inability to Give Consent due to Mental Incapacity

I certify that the above-named Main Applicant/ Family Member is:

- Mentally incapacitated and is unable to provide consent **for this declaration**
- Permanently** mentally incapacitated and is unable to provide consent **for this declaration**

|                         |                              |                                     |
|-------------------------|------------------------------|-------------------------------------|
| _____<br>Name of Doctor | _____<br>Signature of Doctor | Official stamp of clinic/ hospital: |
| _____<br>Date           | _____<br>MCR No.             |                                     |

**Instructions:**

- Date of doctor's certification must be within 6 months from date of submitting this form unless the Main Applicant/ Family Member is permanently mentally incapacitated.
- If the doctor is not present to certify and sign this form, a separate doctor's memo indicating that the Main Applicant/ Family Member is unable to provide consent due to the relevant medical reason may be attached.

### For use by service providers

The Declaration Form is checked by:

Name of Institution: \_\_\_\_\_

Name of Contact Person in the Institution: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email: \_\_\_\_\_

### For Official Use

The Declaration Form is verified/ processed by: