RARE DISORDERS SOCIETY SINGAPORE

Mailing Address : 43 Hindhede Walk #07-08 Singapore 587973
Email Address : contact@rdss.org.sg
Contact No : 6402 2898
Website : www.rdss.org.sg

APPLICATION FORM FOR POWER FOR LIFE PROGRAM

Submission dates for **new application:** Between **1 June - 30 September** & between **1 November - 28 February**
For beneficiaries on long term **ventilator support** (more than a year), please renew your application every year between **1 June - 30 September**.

SECTION A : APPLICANT'S PARTICULARS (must be a registered RDSS Beneficiary)

BENEFICIARY NAME (underline surname) : _____

_____

DATE OF BIRTH (DD/MM/YYYY) : _____/_____/_____ AGE : _____ IDENTIFICATION NO : T / S X X X X ___ ___ ___ ___

GENDER : FEMALE / MALE RACE : _____ NATIONALITY : SINGAPORE / PERMENANT RESIDENT

NAME OF PARENT APPLYING ON BEHALF (underline surname) : _____

RELATIONSHIP TO THE BENEFICIARY : FATHER / MOTHER / GUARDIAN _____

MOBILE NO : _____ EMAIL ADDRESS : _____

RESIDENTIAL ADDRESS :

BLK / NO : _____ UNIT NO : _____ POSTAL CODE : _____

STREET : _____

SPOKEN LANGUAGE(S) : _____ WRITTEN LANGUAGE(S) : _____

APPLICANT'S MEDICAL CONDITION AND NO OF HOURS THAT BENEFICIARY IS ON THE VENTILATOR

MAIN MEDICAL DIAGNOSIS : _____

NATURE OF SUPPORT : ☐ PERMENANT ☐ TEMPORARY

NATURE OF DISABILITY (if any) : ☐ PERMENANT ☐ TEMPORARY -> DURATION OF DISABILTY : _____ (MONTH)

STARTED USING VENTILATOR : _____ (MM/YYYY)

VENTILATOR USAGE TIME : ☐ 24 HOURS ☐ LESS THAN 24 HOURS

SECTION B : ASSESSOR ENDORSEMENT

(ONLY MEDICAL DOCTOR, (MEDICAL) SOCIAL WORKER, HOMECARE / PALLIATIVE NURSING PERSONNEL CAN ENDORSE)

I confirm that the assessment done for the above applicant is true and correct to my best knowledge. I am aware that the assessment for this application will serve as reference only. Rare Disorders Society (Singapore) reserves the right to make the final decision on the application outcome and reject any application if the information is found to be inaccurate, or if any relevant information has been withheld by applicant.

ASSESSOR NAME : _____ HEALTH INSTITUTION : _____

DESIGNATION : _____ EMAIL ADDRESS : _____

CONTACT NO : _____

_____	_____	_____
SIGNATURE	ORGANISATION NAME AND STAMP	DATE

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Mailing Address : 43 Hindhede Walk #07-08 Singapore 587973
Subsidy Forms Mailing Address : 267C Punggol Field #12-127 Singapore 823267
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Website : www.rdss.org.sg

RARE DISORDERS SOCIETY (SINGAPORE)
REIMBURSEMENT FORM FOR POWER FOR LIFE PROGRAM

BENEFICIARY NAME (underline surname) : _____

ITEM NO	MONTH CLAIMING FOR	AMOUNT
1	June - July	
2	August - September	
3	October - November	
4	December - January	
5	February - March	
6	April - May	

TOTAL : _____

PLEASE SELECT YOUR PREFERRED REIMBURSEMENT MODE.

☐ BY PAYNOW (MOBILE NO THAT IS REGISTERED TO YOUR PAYNOW) : _____

☐ BY CHEQUE, PAYABLE TO PAYEE NAME (NAME AS PER BANK RECORDS) : _____

PLEASE HELP TO MAIL THE CHEQUE TO :

BLK / NO : _____ UNIT NO : _____ POSTAL CODE : _____

STREET : _____

NOTE :

(1) Reimbursement(s) can only be made payable to either parent of the beneficiary or the beneficiary himself/herself.

(2) Original application form, with supporting documents must be mailed to RDSS in order to receive the reimbursement.

(3) If you provide any information that is untrue, inaccurate, outdated or incomplete, or if RDSS have any reasonable grounds to suspect so, we reserved the right to reject or cancel your application and/or refuse any current or future application(s) for financial reimbursement(s).

(4) Latest date that RDSS has to receive the application form with the supporting documents : **15 DEC & 30 APRIL**

(5) Refer to the FAQ for more information about the POWER FOR LIFE PROGRAM.

NAME OF PARENT APPLYING ON BEHALF FOR BENEFICIARY : _____

SIGNATURE : _____ **DATE :** _____

FOR RDSS INTERNAL USE ONLY (YOUR NAME AND SIGN OFF)	
CHECKED BY : _____ DATE :	APPROVED BY : _____ DATE :