Mailing Address : **Bedok Central Post Office PO Box 631 Singapore 914608**
Email Address : contact@rdss.org.sg
Contact No : 8088 9294
Website : www.rdss.org.sg

RARE DISORDERS SOCIETY (SINGAPORE)
APPLICATION FORM FOR THERAPY SUPPORT SUBSIDY

Submission cut off dates: 30 November and 30 April
Each beneficiary is allowed to claim up to $1,200 per financial year (for invoices dated 1 June to 30 Apr)

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, put NA if it's self application) : ______________________________

RELATIONSHIP TO THE BENEFICIARY : FATHER / MOTHER / GUARDIAN / SELF

MOBILE NO : ________________________________ EMAIL ADDRESS : _______________________________________

RESIDENTIAL ADDRESS

BLK / NO : _____________________ UNIT NO : ______________________ POSTAL CODE : _________________________

STREET : ____

SPOKEN LANGUAGE(S) : __________________________________ WRITTEN LANGUAGE(S) : ______________________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

If you are claiming for more than one therapy, please fill in additional therapist's details on Page 3.

NAME OF THERAPIST : ____

CLINIC'S NAME : ____

CLINIC'S ADDRESS : ____

CLINIC'S UEN NUMBER : ______________________________ CLINIC'S CONTACT NUMBER : ________________________________

FREQUENCY OF THERAPY : ____

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.

ASSESOR NAME : ____ HEALTH INSTITUION : ______________________________

DESIGNATION : ____ EMAIL ADDRESS : _________________________________

CONTACT NO : ____

________________	________________	________________
SIGNATURE	ORGANISATION NAME AND STAMP	DATE

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RARE DISORDERS SOCIETY (SINGAPORE)
REIMBURSEMENT FORM FOR THERAPY SUPPORT SUBSIDY

BENEFICIARY NAME (underline surname) : ____

ITEM NO	INVOICE NUMBER	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		

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 :

RESIDENTIAL ADDRESS

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 : **30 November & 30 April**

(5) Refer to the FAQ for more information about the THERAPY SUPPORT SUBSIDY

NAME OF PARENT APPLYING ON BEHALF FOR BENEFICIARY / NAME OF BENEFICIARY : _________________________________

SIGNATURE : ________________________ **DATE :** __________________________________

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

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SINGAPORE

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RARE DISORDERS SOCIETY (SINGAPORE)
DETAILS OF ADDITIONAL THERAPIST

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ____

CLINIC'S NAME : ____

CLINIC'S ADDRESS : ____

CLINIC'S UEN NUMBER : ____________________ CLINIC'S CONTACT NUMBER : ____________________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ____

CLINIC'S NAME : ____

CLINIC'S ADDRESS : ____

CLINIC'S UEN NUMBER : ____________________ CLINIC'S CONTACT NUMBER : ____________________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ____

CLINIC'S NAME : ____

CLINIC'S ADDRESS : ____

CLINIC'S UEN NUMBER : ____________________ CLINIC'S CONTACT NUMBER : ____________________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ____

CLINIC'S NAME : ____

CLINIC'S ADDRESS : ____

CLINIC'S UEN NUMBER : ____________________ CLINIC'S CONTACT NUMBER : ____________________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ____

CLINIC'S NAME : ____

CLINIC'S ADDRESS : ____

CLINIC'S UEN NUMBER : ____________________ CLINIC'S CONTACT NUMBER : ____________________