MINISTRY OF HEALTH
SINGAPORE

MSF
MINISTRY OF
SOCIAL AND FAMILY
DEVELOPMENT

Financial Assistance Declaration Form

This form is to be completed by patients/clients who are applying for financial assistance on top of the financial subsidy/grants that they are receiving.

1. Complete this Declaration Form with the particulars of your Immediate Family Members (IFM)[1] and as per the instructions within;
2. Attach clear photocopies (front and back) of:
   (a) NRIC/Birth Certificate[2]/Special Pass of Main Applicant and
   (b) NRIC/Birth Certificate[2]/FIN/Special Pass/Foreign Passport[3] of all IFMs;
3. IFMs listed below must have completed means-testing within the past two years and have a valid means-testing result prior to the release of data for financial assistance; and
4. Submit the completed Declaration Form and all supporting documents to:

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

I am applying for financial assistance at _____

(name of service provider)

Reason for financial assistance: _____

Name (as in NRIC)	NRIC/Birth Certificate /FIN/Special Pass/ Foreign Passport No	IC Type[4]	Date of Birth	Relationship to applicant
(Applicant)				
(IFM)				
(IFM)				
(IFM)				
(IFM)				
(IFM)				
(IFM)				
(IFM)				
(IFM)				

[1] *Immediate family members refer to applicant's parents, spouse and children regardless of whether they are staying with applicant*
[2] *Birth certificates are only applicable for persons below age 15*
[3] *Only applicable to foreigners with no special pass or other passes issued by ICA, MOM or other Government Agencies*
[4] *These are Singapore Citizens, Permanent Residents, Special Pass, FIN and Foreign Passport*

Consent/Declaration (must be signed by Main Applicant aged 21 and above. If the Main Applicant is below 21, the parent or legal guardian must give consent on behalf. If the main applicant is mentally incapacitated, the appointed donee(s) / deputy(s) must give consent on behalf. For Main Applicant who is unable to provide consent, please complete the section **"Unable to Provide Consent or On Behalf Consent"** below.)

I hereby declare that all the information provided in this form is true, correct and accurate to the best of my knowledge. I understand and acknowledge that if any of the information provided in this form is false or inaccurate, I will be liable to repay in full any subsidy and financial assistance granted inclusive of all administrative expenses, and may face criminal prosecution.

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[1]

☐ I/We have consented on behalf of the Main Applicant who is mentally incapacitated[2]

[1] *Please provide a copy of the signatory's NRIC or Passport if not already done so as part of this application.*

[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. Please provide a copy of the Lasting Power of Attorney / Order of Court and NRIC/Passport of the donee(s)/deputy(s) if not already done so as part of this application.*

Section C Unable to Provide Consent or On Behalf Consent

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

Name (as in NRIC): _____

Reason for Inability to Provide Consent or On Behalf Consent *(tick one of the following)*:

☐ 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)
(please fill in doctor's certification below)

☐ In prison ☐ Overseas ☐ Others (please specify) _____

Doctor's Certification for Mental Incapacity

I certify that the above-named Main Applicant is:

☐ mentally incapacitated and is unable to provide consent for this declaration

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

Name of Doctor		Signature of Doctor	Official stamp of clinic/hospital:
Date	MCR No.	Contact No.	

Instructions:

- Date of doctor's certification must be within 6 months from date of submitting this form unless the Main Applicant 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 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: