Application for Community Health Assist Scheme / Healthcare Subsidies

Successful applicants will:

- Enjoy higher subsidies at the public hospital specialist outpatient clinics
- Receive a Health Assist Card and enjoy subsidies at participating Community Health Assist Scheme (CHAS) GP and Dental clinics

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Send to **Bukit Merah Central Post Office, P.O. Box 680, Singapore 911536**

Call **1800-275-2427** for more information

Before you fill in this form, please take note:

Family members living together at the same address (as reflected on the NRIC) need to submit only one combined form. Please include all family members in the form.

Eligibility:

- ☑ Singapore Citizen*
- ☑ For households with income, the household monthly income per person must be $1,800 and below^

  For households with no income, the Annual Value (AV) of home as reflected on the NRIC must be $21,000 and below^^

Documents to submit+:

- ☑ Completed application form
- ☑ If you or any of your family members are foreigners, copies of your foreign identification documents (e.g. work permit / long term visit pass) are also required

* Singapore Citizens who are on the Public Assistance (PA) scheme do not need to apply.

^ Household monthly income per person is the total gross household monthly income divided by total number of family members living together. Gross monthly income refers to your basic income, overtime pay, allowances, cash awards, commissions and bonuses. If you are a salaried employee, your income is based on your average monthly income over the last 12 months. If you are self-employed, your income is based on CPF Board's / IRAS's records within the last 2 years.

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

\+ Incomplete forms lacking consent signatures/thumbprint and/or supporting documents will be sent back to the applicants for completion.

Particulars of Main Applicant

(Please tick ✓) ◯ New application ◯ Renewal

Name (as in NRIC)

NRIC / Birth Certificate / Special Pass No.

NRIC Type

◯ Singapore Pink IC ◯ Singapore Blue IC ◯ Special Pass

Dwelling Type (as per address reflected on NRIC)

◯ HDB Flats ◯ Private Housing (including Executive Condos) ◯ Institution (MOH / MSF licensed home) ◯ Others (e.g. homeless, please specify): _____

Is your place of residence rented?

◯ Yes, renting from Government ◯ Yes, renting from open market ◯ No (e.g. bought or owned)

If you earn **more than $5,000 per month** - please indicate your gross monthly income#

S$

Mailing Address (if different from NRIC)

Contact Details: (Home No.) (Mobile No.) (Email Address) *Please provide below*

_____

Particulars of Family Members living at the same address

Name (as in NRIC)

NRIC / Birth Cert. / FIN / Special Pass

NRIC Type

◯ Singapore Pink IC ◯ Singapore Blue IC ◯ Special Pass ◯ FIN

Relationship to Main Applicant (e.g. spouse, child, parent)

If (i) you earn **more than $5,000 per month** OR (ii) you are a **foreigner** (i.e. not Singapore Citizen or Singapore Permanent Resident) - please indicate your gross monthly income#

S$

Contact Details: (Mobile No.) (Email Address) *Please provide below*

_____

Particulars of Family Members living at the same address

Name (as in NRIC)

NRIC / Birth Cert. / FIN / Special Pass

NRIC Type
○ Singapore Pink IC ○ Singapore Blue IC ○ Special Pass
○ FIN

Relationship to Main Applicant (e.g. spouse, child, parent)

If (i) you earn **more than $5,000 per month** OR (ii) you are a **foreigner** (i.e. not Singapore Citizen or Singapore Permanent Resident) - please indicate your gross monthly income#

Contact Details: (Mobile No.)

(Email Address) *Please provide below*

S$

Name (as in NRIC)

NRIC / Birth Cert. / FIN / Special Pass

NRIC Type
○ Singapore Pink IC ○ Singapore Blue IC ○ Special Pass
○ FIN

Relationship to Main Applicant (e.g. spouse, child, parent)

If (i) you earn **more than $5,000 per month** OR (ii) you are a **foreigner** (i.e. not Singapore Citizen or Singapore Permanent Resident) - please indicate your gross monthly income#

Contact Details: (Mobile No.)

(Email Address) *Please provide below*

S$

Name (as in NRIC)

NRIC / Birth Cert. / FIN / Special Pass

NRIC Type
○ Singapore Pink IC ○ Singapore Blue IC ○ Special Pass
○ FIN

Relationship to Main Applicant (e.g. spouse, child, parent)

If (i) you earn **more than $5,000 per month** OR (ii) you are a **foreigner** (i.e. not Singapore Citizen or Singapore Permanent Resident) - please indicate your gross monthly income#

Contact Details: (Mobile No.)

(Email Address) *Please provide below*

S$

Gross monthly income refers to your basic income, overtime pay, allowances, cash awards, commissions and bonuses.

Consent/Declaration

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) healthcare, aged care, childcare, education, 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.

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[1]
- ☐ I/We have consented on behalf of the Main Applicant who is mentally incapacitated[2]

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[1]
	I hereby confirm that I understand and agree to all the provisions in this form.		☐ I/We have consented on behalf of the Family Member who is mentally incapacitated[2]

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[1]
	I hereby confirm that I understand and agree to all the provisions in this form.		☐ I/We have consented on behalf of the Family Member who is mentally incapacitated[2]

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[1]
	I hereby confirm that I understand and agree to all the provisions in this form.		☐ I/We have consented on behalf of the Family Member who is mentally incapacitated[2]

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[1]
	I hereby confirm that I understand and agree to all the provisions in this form.		☐ I/We have consented on behalf of the Family Member who is mentally incapacitated[2]

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).

Consent/Declaration

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)*:

☐	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)[1] *(please fill in doctor's certification below)*
☐	In prison
☐	Overseas
☐	Others (please specify)

Note:
1. A family member with a donee should have their donee give consent on behalf and does not require a separate doctor's certification of inability to give consent due to mental incapacity.

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**

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 / 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 Official Use

This application is verified/processed by: