Assunta Integrated Social Services
(under the auspices of Assunta Hospital)

APPLICATION FORM TO SEEK ASSUNTA INTEGRATED SOCIAL SERVICES

ASSISS is committed to delivering services to those who are genuinely poor and in need of medical services *(certain medical conditions are excluded)*, provided that the services are available at Assunta Hospital/ ASSISS. Kindly note that only application forms accompanied by the supporting documents (where applicable) listed below will be considered.

1. NRIC copy (patient & family members)
2. Letter from employer certifying salary or salary slips (patient & family members who are working)
3. Latest Employer Provident Fund (EPF) statements (patient & family members who are unemployed)
4. Valid medical certificate (patient & family members who are unfit for work temporarily/permanently due to medical conditions)
5. Most recent three months of detailed bank statements or updated bank book (patient & spouse or parents/caregivers if patient is a minor)
6. Student ID card copy (patient/family members aged 18 and above who are still studying)
7. Proof of expenses (eg. utilities bills, loan, receipts, etc.)
8. *For SWIP only* - Letter from Government Hospital certifying patient's diagnosis, ***recommended surgery***, and date of planned surgery (or indicating long waiting time if there is no planned date)
9. Any other supporting documents that are deemed helpful for ASSISS to understand the family situation.

The decision of the ASSISS Committee is final.

……..

Please tick the service(s) that you are applying for (can tick more than one):

☐ Social Welfare Out-Patient Program (SWOP)
☐ Social Welfare In-Patient Program (SWIP)
☐ ASSISS Wound Care Services (AWCS)
☐ ASSISS Palliative Services (APS) – *please ask for a different application form for this service*

Section A: Patient Information

Diagnosis : _____
Mobility : Independent without aid/ Independent with aid/ Wheelchair-bound/ Bedridden

Patient's Name: _____ NRIC:_____
Sex: Male/ Female Marital Status: Single/ Married/ Separated/ Divorced/ Widowed
Age: _____ Number of Children: _____
Home Address: _____ Home Telephone: _____
_____ Mobile Number: _____

Dwelling Type:
☐ Terraced House – Single-Storey / Double-Storey ☐ Apartment / Flat
☐ Institution: _____ ☐ Others (eg. Homeless):_____
Number of Bedroom(s): _____ Number of Bathroom(s): _____
Is your place of residence rented? Yes / No
Do you have medical insurance? Yes / No

Section B: Family Income Information

Please provide the detailed information of (1) self, nuclear family members living in the same household, and (2) children who are living separately (if any) in tables below:

(1) Nuclear family consists of parent(s) and their children (by blood, marriage, and/or legal adoption) who are living in the same household.

***Other immediate family members living in the same household will be considered on a case-by-case basis.*

Name	Age	Sex	Relationship	Occupation	Company/ School	Monthly Income (RM)	
						Gross	Net
			Self				
Total Number of Household Members =					**TOTAL:**		

(2) Children (by blood, marriage, and/or legal adoption) who are living separately:

Name	Age	Relationship	No. of Dependants	Occupation	Monthly Income (RM)		Monthly Contribution to patient
					Gross	Net	
					TOTAL:		

Other Sources of Income (eg.welfare assistance, SOCSO payout, rental income etc.)**:**

Total: _____

Section C: Savings & Expenses

Savings (of *Patient & Spouse* or *Parents/Caregivers* if patient is a minor)**:**

Account Owner(s)	Bank Name	Account Number	Savings	Statement Date
		TOTAL:		

Monthly Household Expenses:

Rent / House Loan : RM _____
Electricity Bill : RM _____
Water Bill : RM _____
Other Utilities : RM _____
Food : RM _____
Telephone Bill : RM _____
Children Pocket Money : RM _____
Contribution to Parents : RM _____
Auto Loan : RM _____
Petrol : RM _____
Transportation Expenses : RM _____
Insurance : RM _____
Internet : RM _____
Medical Expenses : RM _____
Others - _____ : RM _____
Others - _____ : RM _____
Others - _____ : RM _____
Others - _____ : RM _____
TOTAL : RM _____

DECLARATION

I, ...(IC#.....), hereby declare that all of the information provided in this application form is true and accurate to the best of my knowledge. I understand that the information is used to assess my/family's eligibility for ASSISS services and the submission of the application does not guarantee the provision of ASSISS services. I also understand that my application might not be processed if I do not cooperate in supplying any additional requested information when deemed necessary. The Committee reserves the right to use and disclose all information contained herein to a third party if there is a need.

Signature: Mobile #: Date:

(Relationship to the patient if applicable: ……)

*****FOR ASSISS USE ONLY*****

INTERVIEW OF PATIENT / FAMILY MEMBERS

REFERRAL SOURCE : GOVERNMENT HOSPITAL / NGO / SELF / RENEWAL / OTHERS: _____
INTERVIEW LOCATION : PATIENT'S HOME / ASSISS OFFICE / ASSUNTA HOSPITAL / OVER THE PHONE
INTERVIEW DATE :

PERSONS INTERVIEWED:

1. RELATIONSHIP WITH PATIENT :
2. RELATIONSHIP WITH PATIENT :
3. RELATIONSHIP WITH PATIENT :

GENOGRAM:

RECOMMENDATION:
(For borderline cases, a detailed social report will be attached.)

INTERVIEW CONDUCTED BY:

NAME : **DESIGNATION :**
NAME : **DESIGNATION :**

DECISION BY ASSISS COMMITTEE

☐ **APPROVED** ☐ **NOT APPROVED**

REMARKS :

CONFIRMED BY :

_____

NAME :
DESIGNATION :
DATE :

MEETING DATE:

MEETING CONDUCTED BY:

NAME: **DESIGNATION:**

Last updated in January 2019