Abilities Beyond Limitations and Expectations

APPLICATION FORM

Services Required	
☐ Caregiver Respite	☐ i'mcapABLE *(For person needing care)*
☐ Support Group *(caregiver/ person needing care)*	

APPLICANT PARTICULAR

Name			
NRIC		Date of Birth	
Contact No.	Home : Mobile : Email :	Gender	☐ Male ☐ Female
Address	 Postal Code		
Citizenship	☐ Singaporean ☐ Singapore PR ☐ Others		
Language	☐ English ☐ Mandarin ☐ Malay ☐ Others:_____		
Housing Type	HDB: Room; Private		
Occupation (if any)			
Medical history	Are you currently on any medication? i.e. antidepressant or follow up with counselling? ☐ Yes:_____ ☐ No		

CONSENT AND DECLARATION BY CAREGIVER

I fully understand and agree that the personal data which I have provided to Abilities Beyond Limitations and Expectations Limited (ABLE LTD) is true, accurate and not misleading as at the time of disclosure.

ABLE LTD may also collect personal data about a third party (e.g. my spouse, parents, relatives or children), and when I provide ABLE LTD with such personal data, I confirm that I have obtained the consent of such third party for the disclosure of their personal data to ABLE LTD, and the subsequent processing by ABLE LTD of their personal data.

I consent that the personal data which I have provided to ABLE LTD, including third party personal data, may be disclosed to other agencies or individuals for the purposes as stated below.

a) For the application, and evaluation as beneficiary, for aid and support from ABLE LTD.
b) ABLE LTD verifying or sharing such personal data with and/or seeking aid, donation or support of any kind from, any other individuals, agencies, organisations or institutions (including public or private, social services, voluntary agencies or organisations or churches) on behalf of and for the benefit of myself or the third party.

I agree for ABLE LTD to contact me for any other purposes related to the services that ABLE LTD is providing or had provided me with and/or on matters which I have an ongoing relationship with ABLE LTD.

Name of Caregiver	
Signature of Caregiver	
Date	

Address: 7A Lorong 8 Toa Payoh #02-09 , Agape Village, Singapore 319264 **I Telephone**: +65 6801 7460
www.able-sg.org

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DETAILS OF PERSON NEEDING CARE

Name			
Relationship	☐ Parent ☐ Child ☐ Sibling ☐ Spouse ☐ Friend	Date of Birth	
Contact No.	Mobile :	Gender	☐ Male ☐ Female
Language/Dialect Spoken			
Medical Condition			

FUNCTIONAL STATUS OF PERSON NEEDING CARE

Intellectual impairment:	☐ No ☐ Yes: *Please specify*
Mental illness:	☐ No ☐ Yes: *Please specify*
Visual Impairment:	☐ No ☐ Yes: *Please specify*
Hearing Impairment:	☐ No ☐ Yes: *Please specify*
Speech Impairment:	☐ No ☐ Yes: *Please specify*
Mobility Status	☐ Wheelchair ☐ Ambulant/Walking ☐ With assistance:
Walking Aid:	☐ Nil ☐ Walking stick ☐ Quad Stick ☐ Walking frame ☐ Others
Bathing/Showering	☐ Independent ☐ Needs Assistance
Dressing	☐ Independent ☐ Needs Assistance
Feeding	☐ Independent ☐ Needs Assistance
Toileting	☐ Independent ☐ Needs Assistance
Transfers	☐ Independent ☐ Needs Assistance
Bowel/Bladder Control	☐ Continent ☐ Incontinent
Wound	☐ Nil ☐ Yes

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This page is to be completed if application is submitted by the referral agency/organization

Reason(s) For Referral/Application *(You may select more than one option)*		
☐ Emotional Support ☐ Financial Assistance ☐ Family conflict ☐ Other reason(s) _____		
Has household means test been conducted for client? *Please submit relevant documentation.*	☐ Yes Subsidy Rate:_____% Date of Expiry: _____	☐ No
Genogram		
Brief family background and Support Networks/Ecosystem *including other supporting agencies,hospitals,etc.*		
Consent for Referral		
Note: To enable ABLE to process this application, the applicant/next-of-kin must agree to this referral, so that ABLE may begin to contact them directly and, consent to the disclosure of information in this application to Caritas-Singapore / relevant agencies or service providers, as required. **Applicant/ Next-of-Kin agreed this referral and consent has been given, on (date) : _____** **Agreed/Consent by (please circle:) Applicant / Next-of-Kin (name:)_____**		
Referral Source Information		
Name:	Designation:	Telephone:
Organisation name:	Adress:	Date:

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