Functional Assessment Report
功能评估报告

IMPORTANT NOTE: This report assesses the need for assistance in Activities of Daily Living and is only for the purpose of application of specific government schemes administered by AIC (i.e. Pioneer Generation Disability Assistance Scheme, Foreign Domestic Worker (FDW) Grant and FDW Levy Concession for Persons with Disabilities), SG Enable, SNTC and HDB. It is NOT valid for the Interim Disability Assistance Programme for the Elderly (IDAPE) or ElderShield. If you are applying for IDAPE, please visit an appointed IDAPE assessor to complete the IDAPE Assessor Statement. If you are applying for ElderShield, please use the ElderShield claim form. More information on ElderShield is available from the websites of Aviva, Great Eastern and NTUC Income. Please contact the individual agencies if there are further queries on the other government schemes.

Any Singapore-registered doctor's memo or document certifying that person needing assessment is permanently bedridden may be accepted in lieu of the functional assessment report.

要注：这份报告旨在评估一个人在日常生活活动中是否需要帮助，唯一目的是用来申请护联中心（如：建国一代残疾人士援助计划（PioneerDAS）、女佣雇主补贴(FDW Grant)，以及外籍女佣减税计划（残疾人士）(FDW Levy Concession for Persons with Disabilities）、新加坡协助残疾人自立局、特需信托机构及建屋局等机构管理的特定政府计划。它不适用于申请乐龄中期残障援助计划(IDAPE)或乐龄健保计划(ElderShield)。若是您想申请乐龄中期残障援助计划，请安排该计划的指定评估员为您填写评估表格。若是您想申请乐龄健保计划,请使用乐龄健保索赔表格。欲知更多有关乐龄健保计划的详情，请参阅Aviva、大东方及职总英康保险公司网站。关于其他政府计划的询问，请联系个别的相关机构。

如拥有新加坡注册医生的备忘录或文件证明申请人需长期卧床，申请人无需进行日常生活活动能力的评估。

SECTION A: TO BE COMPLETED BY PERSON NEEDING ASSESSMENT / CAREGIVER
A 组：由需要评估 / 看护人者填写

Name of Person Assessed : _____
受评估者姓名

NRIC/BC : _____
身份证 / 出生证号码

Important: Please proceed to complete this form, only if the person has required assistance in Section A Part 1 (iii) to (viii) for more than 6 months and/or if the person needing assessment will require assistance in Section A Part 1 (iii) to (viii) on a permanent basis.
注意：唯有在受评估者已在 A 组第 1 部分（iii）至（viii）项中需要超过 6 个月的援助及 / 或将在 A 组第 1 部 分（iii）至（viii）项中需要永久性帮助的情况下才填写这份表格。

1 INFORMATION ON FUNCTIONAL STATUS (TO BE COMPLETED BY CAREGIVER OR THE PERSON NEEDING ASSESSMENT)
关于功能状况的资料（由看护人/需要评估者填写）
Please provide additional information to aid the assessment.
请提供额外资料以助评估。

Please circle the answers that apply for the person needing assessment:
请圈出适用于需要评估者的答案：

i	Does the person assessed need a mobility aid when indoors? 受评估者在户内时是否需要助行器？	Yes / No 需要 / 不需要
ii	If "Yes", please indicate the mobility aids used: 若是"需要"，请注明所使用的助行器： ☐ Wheelchair (Powered / Manual) 轮椅（电动 / 人工） ☐ Artificial Limbs / Devices 义肢 / 器具 ☐ Crutches 拐杖	

	☐ Walking Cane / Quad Stick 助行藤杖 / 四脚拐杖 ☐ Walking Frame (with/without wheels) 助行框（有轮 / 无轮） ☐ Others (please specify) 其他（请注明） _____	
iii	Does the person need help to transfer from bed to chair (or bed to wheelchair) and vice versa? 受评估者从下床到椅子（或轮椅）上或从椅子（或轮椅）到上床 时是否需要帮助？	Yes / No 需要 / 不需要
iv	Does the person need help to move (with or without walking aids or wheelchair) between his or her room to the toilet in his or her home? 受评估者在家里是否需要帮助才能从房间去厕所（有或无助行器或轮椅？	Yes / No 需要 / 不需要
v	Does the person need help to use the toilet and to clean himself or herself after passing motion or urination? 受评估者如厕时及大小便后清理自己是否需要帮助？	Yes / No 需要 / 不需要
vi	Does the person need help to bathe and dry himself or herself (excluding the back)? 受评估者洗澡或擦干身体（背部除外）时是否需要帮助？	Yes / No 需要 / 不需要
vii	Does the person need help to wear and take off both upper and lower body clothing? 受评估者穿衣穿裤及脱衣脱裤时是否需要帮助？	Yes / No 需要 / 不需要
viii	Does the person need help to cut up food, bring the food to the mouth, chew and swallow? 受评估者割切食物、把食物放进嘴巴、咀嚼及吞咽时是否需要帮助？	Yes / No 需要 / 不需要
ix	Approximately, when did the person first require assistance with (iii) to (viii), where applicable? 受评估者首次需要（iii）至（viii）项援助时（适用之处）大概是在什么时候？	_____/_____ (MM/YYYY) _____/_____（月份/年份）

2 Declaration by Person Needing Assessment / Caregiver
需要评估 / 看护人者宣誓

I declare that the above information has been provided to the best of my knowledge, true and correct. I give consent to the assessor to use the above information for the functional assessment. I also declare that I have not withheld any relevant information or made any misleading statement. I give my consent to the assessor to communicate with any physician who has attended to me.

我宣誓，以上资料是根据我所知提供的，并且属实和正确。我同意让评估者使用以上资料为参考。我也宣誓，我没有隐瞒任何相关资料或作出任何误导性声明。我同意让评估者与任何曾治疗我的医生沟通。

Name and Signature of Person needing Assessment / Caregiver 需要评估 / 看护人者姓名及签名	I/C Number 身份证号码	Date 日期

SECTION B: TO BE COMPLETED BY ASSESSOR (i.e. SMC FULLY REGISTERED DOCTOR, SNB REGISTERED NURSE OR FULLY REGISTERED PHYSIOTHERAPIST / OCCUPATIONAL THERAPIST UNDER AHPC)

FUNCTIONAL ASSESSMENT

Patient's Sticky Label (where applicable)

(if no patient's sticky label)

Name of Patient : _____

NRIC/BC : _____

1 Activities of Daily Living (ADLs)*

		Requires help/supervision from an assistant.	Independent – No help is required.
i	Mobility	☐	☐
ii	Washing or Bathing	☐	☐
iii	Dressing	☐	☐
iv	Feeding	☐	☐
v	Toileting	☐	☐
vi	Transferring	☐	☐

2 Comments

Please estimate when the assistance with the ADLs first started. _____ / _____ (MM/YYYY)

If the onset of the assistance with ADLs is less than 6 months ago, please indicate whether the need for assistance will be required for at least another 6 months.

☐ **Yes, required for another 6 months** ☐ **No**

Additional Comments (e.g. whether the need for assistance is of permanent nature, or unlikely to require permanent assistance due to recovery potential): _____

I confirm that the assessment done for the above applicant is true and correct to my best knowledge, and with reference to the declaration made by the applicant in Section A. I am aware that the assessment for this application will serve as reference only. The Scheme Administrator 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 the applicant.

Name, Registration No. & Signature of Assessor	Stamp of Organisation / Clinic / Hospital	Date	Tel / Fax Nos.

Important Note: *Assessor must sign against any amendment made and affix the official stamp of the organisation / clinic / hospital. If not, the report will be deemed to be incomplete.*

**** Notes for Assessor***

a. *Washing or Bathing* — *Needs help to wash body (excluding back) in the bath, shower or sponge/bed bath. Includes subcomponents of washing, rinsing and drying.*

b. *Dressing* — *Needs help to put on, take off, secure and unfasten garments (upper and lower) and any braces, artificial limbs or other surgical appliances.*

c. *Feeding* — *Needs help to feed oneself after food has been prepared and made available.*

d. *Toileting* — *Needs help to use the toilet and manage bowel and bladder hygiene. Consists of (i) maintenance of balance during the act of urination or defecation and clothing adjustment, and (ii) maintaining perineal hygiene such as using toilet paper to clean the perineum. Independent of actual bowel or bowel functions e.g. incontinence. Does not include changing of long-term indwelling catheter under toileting.*

e. *Transferring* — *Needs help to transfer from bed to an upright chair or wheelchair, and vice versa. Includes sit-up from a lying position, a sit to standing position, a weight or pivot shift and a controlled descent to a sitting position in another location.*

f. *Mobility* — *Needs help to walk indoors or move in a wheelchair from room to room on level surface for about 8 meters (about twice the length of a clinic). This is regardless of the use of walking aid and the speed of walking.*

ONLY FOR APPLICATION OF FOREIGN DOMESTIC WORKER GRANT SCHEME

SECTION C: TO BE COMPLETED BY CAREGIVING TRAINER

CAREGIVER TRAINING RECEIVED BY FOREIGN DOMESTIC WORKER (if applicable)

(for use by authorised caregiver trainer only)

1 Details of FDW Trained (must complete)

Name of Foreign Domestic Worker (FDW) : _____

FIN / Work Permit/ Passport No. of FDW : _____

2 FDW has been trained in the following components (please tick)

☐ Washing / Bathing / Personal Hygiene	☐ Dressing	☐ Transferring / Bed Care
☐ Feeding / Medication Serving	☐ Toileting	☐ Mobility

☐ Others (please state) _____

I confirm that the training done for the above applicant is true and correct. I am aware that the training for this application will serve as reference only. The Scheme Administrator 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 the applicant.

Name and Signature of Trainer	Stamp of Organisation	Date	Tel / Fax Nos.

Trainer must sign against any amendment made and affix the official stamp of the organisation. If not, the report will be deemed to be incomplete.

If training is done by a Caregiver Training Grant Training Provider, please do not use this form