

Functional Assessment Report

功能评估报告

IMPORTANT NOTE:

(1) This Functional Assessment Report (“FAR”) assesses a person needing assessment’s need for assistance with the Activities of Daily Living (“ADLs”) and is only for the purpose of application for specific government schemes administered by (i) the Agency for Integrated Care (the Pioneer Generation Disability Assistance Scheme, Home Caregiving Grant and Foreign Domestic Worker Levy Concession for Persons with Disabilities), (ii) SG Enable (Public Transport Concession for Persons with Disabilities), (iii) the Special Needs Trust Company (Special Needs Savings Scheme) and (iv) the Housing & Development Board (Enhancement for Active Seniors) (collectively, “Long-Term Care Schemes”).

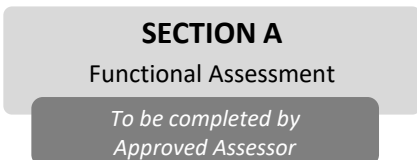
It CANNOT be used for the Interim Disability Assistance Programme for the Elderly (“IDAPE”) and ElderShield schemes:

- (a) If you are applying for IDAPE, please visit an IDAPE-appointed assessor to complete the IDAPE Assessor Statement. More information on IDAPE can be obtained from the Agency for Integrated Care or www.aic.sg;
- (b) 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.

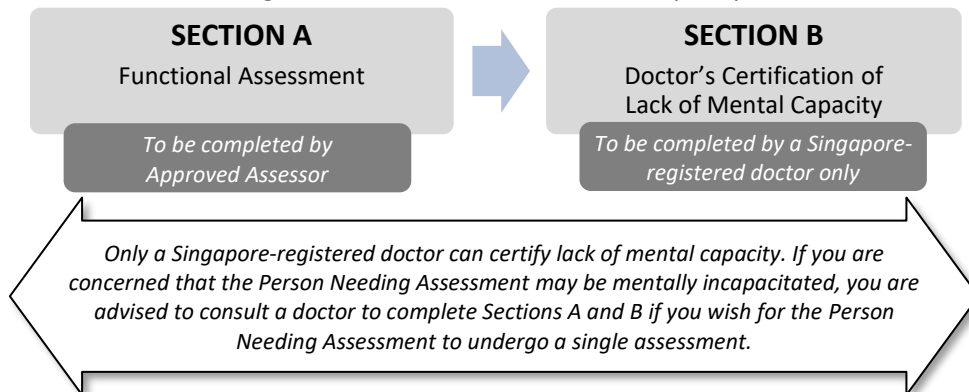
(2) Any Singapore-registered doctor's memo or document certifying that the person in respect of whom the application(s) is/are made (“Person Needing Assessment”) is permanently bedridden, may be accepted in lieu of this FAR.

(3) This FAR should be completed by the parties set out below:

For Person Needing Assessment who has mental capacity



For Person Needing Assessment who lacks mental capacity



(4) “Approved Assessors” shall be:

- a. doctors who are under full or conditional registration with the Singapore Medical Council;
- b. registered nurses who are under full or conditional registration with the Singapore Nursing Board;
- c. physiotherapists who are under full, conditional or restricted registration with the Allied Health Professions Council (“AHPC”); and
- d. occupational therapists who are under full, conditional or restricted (restricted scope classification - “Physical dysfunction/ Adults and older adults” only) registration with AHPC.

Note: Persons Needing Assessment who are aged below 8 years must be assessed by Pediatricians, unless they are bedridden, in which case, paragraph 2 above applies.

SECTION A: TO BE COMPLETED BY APPROVED ASSESSOR¹**FUNCTIONAL ASSESSMENT**

Name of Person Needing Assessment: _____

Person Needing Assessment's Sticky Label

NRIC/Birth Certificate No.
of Person Needing Assessment: _____**Activities of Daily Living ("ADLs")***Please complete the assessment for all 6 ADLs. If any of the ADLs is **left blank**, it will be taken that the Person Needing Assessment is **independent** in performing the ADL.

		Requires help/supervision	Independent – No help is required
i	Mobility	<input type="checkbox"/>	<input type="checkbox"/>
ii	Washing or Bathing	<input type="checkbox"/>	<input type="checkbox"/>
iii	Dressing	<input type="checkbox"/>	<input type="checkbox"/>
iv	Feeding	<input type="checkbox"/>	<input type="checkbox"/>
v	Toileting	<input type="checkbox"/>	<input type="checkbox"/>
vi	Transferring	<input type="checkbox"/>	<input type="checkbox"/>

Please estimate when the Person Needing Assessment first required assistance with the ADLs.

_____ / _____ (MM/YYYY)

Please indicate whether the need for assistance will be required for at least another 6 months from date of assessment. Yes, required for at least another 6 months from date of assessment No**Approved Assessor's Declaration And Signature**

I have assessed the above Person Needing Assessment and confirm that the information set out in Section A of this form is true and correct to the best of my knowledge.

 I declare that the Person Needing Assessment is related to me, or otherwise known to me outside my capacity as a registered healthcare professional. The Person Needing Assessment is my family member or relative / friend / employer / employee / others*(please elaborate: _____). **Please delete accordingly.*

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

Important Note: Approved Assessor must sign against any amendment(s) made and affix the official stamp of the organisation / clinic / hospital, failing which, the FAR will be deemed incomplete and may be rejected.**Notes for Assessor**

- a. **Mobility** Needs help to walk indoors or move in a wheelchair from room to room on level surface for about 8 metres (about twice the length of a clinic). This is regardless of the use of walking aid(s) and the speed of walking.
- b. **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.
- c. **Dressing** Needs help to put on, take off, secure and unfasten garments (upper and lower) and any braces, artificial limbs or other surgical appliances.
- d. **Feeding** Needs help to feed oneself after food has been prepared and made available.
- e. **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 bladder functions e.g. incontinence. Does not include changing of long-term indwelling catheter.
- f. **Transferring** Needs help to transfer from bed to an upright chair or wheelchair, and vice versa. Includes (i) sitting up from a lying position; (ii) moving from a sitting to standing position; (iii) a weight or pivot shift; and (iv) a controlled descent to a sitting position in another location.

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- registered nurses who are under full or conditional registration with the Singapore Nursing Board;
- physiotherapists who are under full, conditional or restricted registration with the Allied Health Professions Council ("AHPC"); and
- occupational therapists who are under full, conditional or restricted (restricted scope classification - "Physical dysfunction/ Adults and older adults" only) registration with AHPC.

SECTION B: TO BE COMPLETED BY DOCTOR REGISTERED WITH SINGAPORE MEDICAL COUNCIL

DOCTOR'S CERTIFICATION FOR PERSON NEEDING ASSESSMENT WHO LACKS MENTAL CAPACITY

Name of Person Needing Assessment: _____

NRIC/ Birth Certificate No.
of Person Needing Assessment: _____

Person Needing Assessment's Sticky Label

Lack Of Mental Capacity To Provide Consent

Does the person needing assessment lack mental capacity to give consent for the application for, or handling of monetary payouts from, long-term care schemes?

Yes No

If yes, is the lack of mental capacity to provide the consent permanent?

Yes No

Doctor's Declaration And Signature

I have assessed the above Person Needing Assessment and confirm that the information set out in this Section B is true and correct to the best of my knowledge.

I declare that the Person Needing Assessment is related to me, or otherwise known to me outside my capacity as a registered healthcare professional. The Person Needing Assessment is my family member or relative / friend / employer / employee / others*(please elaborate: _____). **Please delete accordingly.*

Name, MCR No. and
Signature of Doctor

Stamp of Clinic/ Hospital

Date

Tel / Fax Nos.