


SMF Assistive and Motorised Device Guide

We encourage you to submit your application online. Online applications are simpler to fill up and can be processed faster.


Simply scan the QR code.

With Singpass



https://for.sg/smf-application-using-singpass

Without Singpass



https://for.sg/smf-application-with-sing-singpass

Eligibility Criteria

- Singapore Citizen aged 60 and above.
- Means-tested:
 - o Household monthly income per person¹ is
 - o \$2,600 or less; or
 - o Annual value of property for household without income is \$21,000 or less.
- Be living in the community.
- Does not have a full-time caregiver or migrant domestic worker for your caregiving needs. (For motorised device application only)

Documents to be submitted

- Completed Application Form
- Copy of your NRIC (front and back) or image copy of Digital NRIC through Singpass App
- Copy of Financial Assistance documents (e.g. valid Comcare, Medifund, PA Card)
- Medical reports - Compulsory for 1st time motorised device application only (e.g Needs of Assessment form, doctor's memo describing applicant's medical condition)

Important Information to Note





You must be able to co-pay for assessment fee, cost of assistive & motorised device and ramp installation (if required for motorised device application).

If you have submitted your application online, you do not need to fill up this application form.







If you need to use this hardcopy application form, please note that the **hardcopy application form may take about 15 - 20 minutes to complete.**

¹Household monthly income per person includes CPF contributions, basic income, overtime pay, allowances.

What are the steps for the application?












			
<p>Submit the completed application form and supporting document to AIC OR apply via your Singpass (applicant) which is simpler.</p>	<p>Attend and pass both the assessment and *training at any of our assessment centre.</p>	<p>*Installation of ramps is compulsory for HDB units with steps at the main door. You can visit HDB EASE for more information.</p> <p>Parking of motorised device at the corridor is strictly not allowed.</p>	<p>Ordering of device will be made and supplier will reach out to you on the delivery arrangements.</p> <p>Completion date could be longer if the selected model is out of stock. For such situation, do discuss with the assessor if you would like to change to another model.</p>

*For motorised device application only

You may submit your application via	For more information
<ul style="list-style-type: none">  Email to smf.community@aic.sg  Post to 7 Maxwell Road, MND Complex Annex B, #04-01, Singapore 069111  Walk in to any AIC Link. To find an AICare Link near you, visit https://www.aic.sg/AIC-Link 	<ul style="list-style-type: none">  Visit www.aic.sg  Call 1800 650 6060  Visit AIC Link

SMF Assistive and Motorised Device Categories with Blackout Period (Months)

- All pictures are for illustration purposes only. The actual device may differ from the pictures.
- Blackout period refers to the minimum device's usage duration to be met from previous SMF application for replacement application.

Assistive Device Categories	
<p>(a) Walking Aids (36 months)</p> 	<p>(b) Wheelchair / Pushchair (36 months)</p> 
<p>(c) Pressure Relief Cushion (24 months)</p> 	<p>(d) Commode (24 months)</p> 
<p>(e) Hospital Bed (48 months)</p> 	<p>(f) Pressure Relief Mattress (24 months)</p> 
<p>(g) Special Equipment (36 months) e.g. Oxygen Concentrator, Suction Pump, Hoist</p> 	<p>(h) Geriatric Chair (48 months)</p> 
<p>(i) Spectacles¹ (24 months)</p> 	<p>(j) Hearing Aids (per pair)² (48 months)</p> 
Motorised Device	
<p>(k) Motorised Device (36 months)</p> 	

¹ Application and assessment for spectacles will be directed to AIC appointed partners.

² For hearing aids applications, Applicant is required to obtain a referral letter from a polyclinic or CHAS clinic for a subsidised hearing assessment at the public hospital. The Audiologist / ENT specialist will assess your needs and assist with your SMF application.

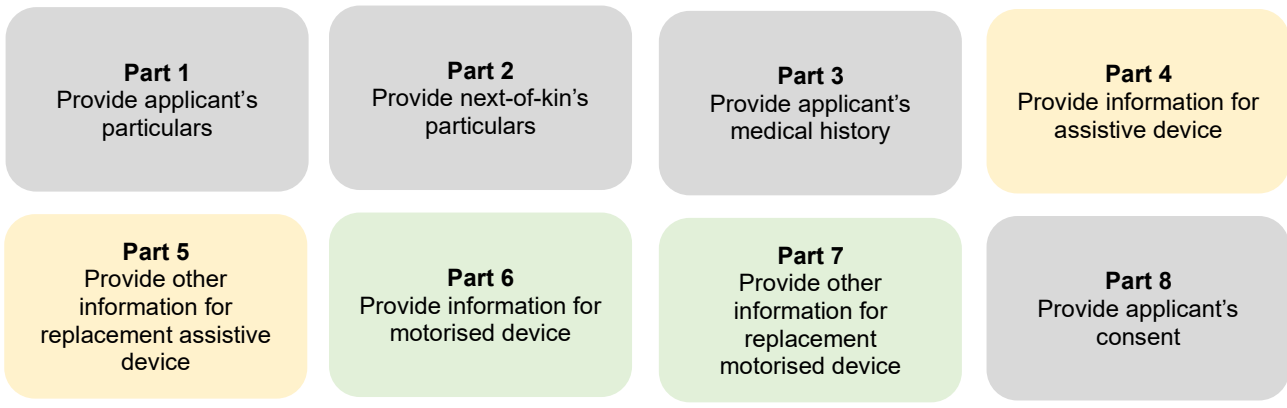
For Assistive Device application

You are required to complete **Part 1, 2, 3, 4 and 8** of the application form for **First Assistive Device**.
 You are required to complete **Part 1, 2, 3, 4, 5 and 8** of the application form for **Replacement Assistive Device**.

For Motorised Device application

You are required to complete **Part 1, 2, 3, 6, 7 and 8** of the application form for **First or Replacement of Motorised Device**.

For replacement of battery, **Part 1, 2, 6 and 8** are required.



Part 1: Particulars of Applicant																			
Name (according to NRIC)		NRIC																	
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Date of Birth (DD/MM/YYYY)		Race																	
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D	D	/	M	M	/	Y	Y	Y	Y										
Gender	Home contact number		Mobile number																
<input type="checkbox"/> Male <input type="checkbox"/> Female	<table border="1" style="width: 100%;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table>										<table border="1" style="width: 100%;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table>								
Address (according to NRIC)																			




Part 2: Particulars of Next-Of-Kin/Contact person											
Name (according to NRIC)			Contact number								
			<table border="1" style="width: 100%;"> <tr> <td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td><td style="width: 20px;"></td> </tr> </table>								
Relationship to Applicant <small>(you are the applicant's)</small>	<input type="checkbox"/> Spouse	<input type="checkbox"/> Son / Son-in-law	<input type="checkbox"/> Daughter / Daughter-in-law <input type="checkbox"/> Others <small>Please specify:</small>								
Email address											

Part 3: Medical Condition/ history of Applicant			
3a Are you or anyone living with you have/had any infectious disease within the last 3 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3b Do you have a medical appointment at any hospital in the next 2 months?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, name of hospital:		Date of Appointment:	
3c Are you receiving any centre-based services?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please state name of service provider:			

Part 4: For SMF Assistive Device Application				
4a Type of Device Application				
<input type="checkbox"/> Walking Aids (eg: Walking Stick, Walking Frame and Quadstick)	<input type="checkbox"/> Manual Wheelchair / Pushchair	<input type="checkbox"/> Pressure Relief Cushion	<input type="checkbox"/> Commode	<input type="checkbox"/> Hospital Bed
<input type="checkbox"/> Pressure Relief Mattress	<input type="checkbox"/> Special Equipment (eg: Bed Rail, Hoist, Transfer Board, Transfer Belt)	<input type="checkbox"/> Geriatric Chair	<input type="checkbox"/> Spectacles Please register for the next Functional Screening Event in your neighbourhood.	<input type="checkbox"/> Hearing Aids Please submit your application through your audiologist in the Restructured Hospitals.
4b Type of mobility aid and assistive device that applicant is currently using				
<input type="checkbox"/> None	<input type="checkbox"/> Walking Stick	<input type="checkbox"/> Quadstick	<input type="checkbox"/> Walking Frame	
<input type="checkbox"/> Rollator Frame	<input type="checkbox"/> Wheelchair / Pushchair	<input type="checkbox"/> Geriatric Chair	<input type="checkbox"/> Others Please indicate:	

Part 5: Additional Declaration for Assistive Replacement Device Application Only	
5a Provide the following information regarding the previously SMF approved device to be replaced	
Device Category / Type Received:	(e.g: Wheelchair)
Device Vendor, Model and Brand:	(Indicate NA if not available)
Month and Year Device Received:	(Indicate NA if not available) (MMM/YYYY)
<p>Please inform us if you would you like the replacement to be the same or similar model as the device to be replaced.</p> <p>Please answer "Yes" only if you have determined that the previous device is sufficient to serve your needs, and you do not require a device assessment to be conducted.</p>	
5b	
Please answer "No" if the current device is insufficient or if you would like a device assessment to be conducted.	
Please note that AIC may still require an assessment to be conducted and you may still be assigned a replacement device of the same or similar model if such model is assessed to be sufficient for your needs.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

Part 6: For SMF Motorised Device Application	
<input type="checkbox"/> First motorised device under SMF	
<input type="checkbox"/> Replacement device	Was your current device applied through SMF?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Battery Replacement	You are currently using a
	<input type="checkbox"/> Motorised scooter <input type="checkbox"/> Motorised wheelchair
Brand and Model:	
Brand	
Model	
Preferred Training Vendor (Subject to vendors' availability. Not required for battery replacement)	
<input type="checkbox"/> Handicaps Welfare Association	<input type="checkbox"/> Jurong Community Hospital
<input type="checkbox"/> Kwong Wai Shiu Hospital	<input type="checkbox"/> Society for the Physically Disabled
<input type="checkbox"/> St Luke's Hospital	

Part 7: Other Information		
7a Are there steps at your main door?		
<input type="checkbox"/> No steps 	<input type="checkbox"/> 1 step 	<input type="checkbox"/> > 1 step 
If there are step(s), do you have a ramp installed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7b Do you have a caregiver (family member/migrant domestic worker) living in the same household?		<input type="checkbox"/> Yes <input type="checkbox"/> No
7c Is your caregiver able to take care of you full-time?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please state reason:		
7d Are you able to push yourself around in the community on a manual wheelchair?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, please state reason:		

Part 8: Consent and Declaration	
<p>I declare that all the information provided for my application is true, correct and accurate to the best of my knowledge.</p> <p>I acknowledge that I have read and accepted the Terms and Conditions (page 6) of this application.</p> <p><u>For Assistive Device application</u> I agree to co-pay the assessment fee and device cost. I understand that the assessment fee is non-refundable regardless of the application outcome. I agree to attend the assessment, if applicable, by means of my own transportation and at my own expense.</p> <p><u>For Motorised Device / Battery Replacement application</u> I agree to co-pay the training and assessment fee and device cost / battery replacement cost. I understand that the training and assessment fee is non-refundable regardless of the application outcome. I agree to attend the training and assessment, if applicable, by means of my own transportation and at my own expense.</p> <p>I agree that my needs, suitability and eligibility for a subsidised assistive and/or motorised device will be assessed by the qualified assessor during the assessment. If assessed to be suitable and eligible, I may be prescribed a device based on my medical and mobility needs. The decision of the type and model of the prescribed device shall rest with AIC and the qualified assessor, and the decision is final.</p>	
Signature/ thumbprint of Applicant and date <div style="border: 1px solid black; height: 40px;"></div>	Signature/thumbprint of Next-of-Kin (authorised [#] to act on the Applicant's behalf) and date <div style="border: 1px solid black; height: 40px;"></div>

[#] Next of Kin to sign on behalf of applicant without mental capacity and the NOK accepts the terms of the application.

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TERMS AND CONDITIONS

DECLARATION

1. I affirm that all the information provided in my application for Seniors' Mobility and Enabling Fund (SMF) subsidy which includes all the documents submitted, is true and correct to the best of my knowledge, and I have not deliberately omitted any necessary information relevant to this application.
2. I am aware that Agency for Integrated Care ("AIC") has the right to recover the SMF subsidy given to me, if I do not pass the Means-Test criteria, have provided any false or inaccurate information, or withheld any relevant information from the Qualified Assessor³ and/or administration staff of the Organisation administering the Services and Schemes.
3. I am not currently an applicant or recipient of any other public or private grant or subsidy (that exceeds the applicable co-payment amount by me under the SMF Devices scheme), and will not be applying for such grant or subsidy, in respect of the same or similar device(s) being applied for under the SMF Devices scheme.
4. If my application is for a replacement device, I affirm that my previous device(s) is no longer usable and/or discarded.
5. If my application is for repair of device, I am aware that the repair warranty would cover only the repair service and the replacement parts. The repair warranty period would be shorter compared to warranty period of a new replacement device, and the repair would restart the clock for blackout period for the device.
6. I will fully indemnify AIC, the Organisation administering the scheme and the Government of the Republic of Singapore against any loss, damage, cost and expense whatsoever, including any legal cost on a full indemnity basis, which may be incurred by AIC, the Organisation administering the scheme and the Government of the Republic of Singapore as a result of any false or inaccurate information given by me or my failure to comply with my obligations.
7. I have read and understood all the terms and conditions of my application and agree to be bound by them.
8. I agree to abide by AIC's decision regarding my application, which is final.

CONSENT FOR DISCLOSURE AND USE OF PERSONAL INFORMATION

9. I understand that the sharing of Personal Information⁴ between different entities such as the Government, and certain participating statutory boards and organisations approved by the Government, will assist in the evaluation of my suitability and eligibility for Services and Schemes⁵.
10. I agree that any Cooperating Party may:
 - a. collect my Personal Information from me or any of the other Cooperating Parties⁶;
 - 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: evaluating my suitability and eligibility for Services and Schemes at any time; the administration and provision of Services and Schemes in relation to me; and/or data analysis, evaluation and policy formulation, in which I shall not be identified as specific individuals or households (collectively known as the "Purposes").
11. I understand and accept that AIC's Data Protection Policy (available at <https://www.aic.sg/data-protection-policy>) also applies to the collection, use and/or disclosure of my Personal Information by AIC. Therefore, in addition to the Purposes which I have consented to above, I also consent to the collection, use and/or disclosure of my Personal Information by AIC for the purposes set out in AIC's Data Protection Policy.
12. I consent to AIC and/or the Organisation administering the Services and Schemes in obtaining the applicant's medical information from any healthcare professional who is providing or has provided medical care, treatment to, or has medically assessed the senior.
13. This consent shall be governed by and construed in accordance with the laws of the Republic of Singapore.

TERMS AND CONDITIONS APPLICABLE FOR SMF ASSISTIVE AND MOTORIZED DEVICES SUBSIDY APPLICATION

14. I allow AIC and/or the Organisation administering the Services and Schemes to access my Means Test result from the National Means Test System for the purpose of this application.
15. I will not hold AIC and/or the Organisation administering the Services and Schemes liable if my Means Test result has expired and I am unable to qualify for the SMF subsidy.
16. I have been briefed by AIC and/or the Organisation administering the Services and Schemes and will be expected to and will make the required co-payments after the SMF subsidy. I agree that any co-payment amounts incurred as part of assessment and is non-refundable regardless of the application outcome.
17. I agree that I am responsible for the management and maintenance of the assistive and motorised devices issued for my use, and not the responsibility of AIC and/ or the Organisation administering the Services and Schemes or the assistive devices vendors.
18. I will not hold AIC, the Organisation administering the Services and Schemes or any related assessors, liable for accidents and/or incidents related to the use of the assistive and motorised devices issued or repaired and for the duration of the client education session provided.

³ "Qualified Assessor" is in accordance to SMF Qualified Assessor List, and subjected to the type of device prescribed. This includes fully registered physiotherapists, fully registered occupational therapists, registered nurses, registered doctors, certified audiologists, fully registered optometrists, centre managers and SMF personnel trained in administering the Simplified Assessment Tool.

⁴ "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 of this application.

⁵ "Services and Schemes" means social services schemes, financial assistance schemes and insurance schemes, including: the SMF Scheme; financial assistance schemes and insurance schemes administered by AIC; healthcare, aged care, childcare, education, social assistance and counselling services and schemes; any form of financial assistance such as subsidies, grants, tax reliefs, levy concessions, vouchers or bursaries; and retirement, savings and insurance schemes operated by the Government, CPF Board or their appointed agents (including Medisave and MediShield Life).

⁶ "Cooperating Parties" shall refer to the Government of the Republic of Singapore (the "Government") and participating statutory boards and organisations approved by the Government, including AIC and the approved organisations that are involved in or assisting in the provision and delivery of the Services and Schemes.

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The purpose of this form is to assess that the person needing assessment has needs for a motorised device, in order to apply for subsidy under the Seniors' Mobility and Enabling Fund (SMF).

TO BE COMPLETED BY A DOCTOR REGISTERED WITH THE SINGAPORE MEDICAL COUNCIL

DOCTOR'S CERTIFICATION - FOR NEED OF A MOTORISED DEVICE

Name of Person Needing Assessment: _____

NRIC of Person Needing Assessment: _____

Sticky Label of Person Needing Assessment

Doctor's Assessment

1. Does the person needing assessment require the use of a motorised device due to the medical condition? If you have ticked "Yes" below, please proceed to Question 2 & 3.

Yes No
2. Does the person needing assessment has any condition that will affect the operation of a motorised device?

Yes No
3. If yes, the person assessed will require the motorised device for at least 3 months?

Yes No
4. Any other information relating to the person's application for a motorised device.

Doctor's Declaration and Signature

Please tick one only:

- The Person Needing Assessment is **not related to me**.
- The Person Needing Assessment **is related to me**, or otherwise known to me outside my capacity as a registered healthcare professional. I declare that the Person Needing Assessment is my family member or relative / friend / employer / employee / others*(please elaborate: _____). **Please delete accordingly.*

Declaration

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

Name Stamp, Registration No. & Signature of Doctor	Stamp of Organisation / Clinic / Hospital	Date	Tel No.

Important Note: Any amendment(s) made must be signed by Doctor and affix the official stamp of the organisation / clinic / hospital, failing which, the form will be deemed incomplete and may be rejected.