SNTC (SNSS) Reference Number: **SNSS /** / /

APPLICATION FORM FOR SPECIAL NEEDS SAVINGS SCHEME (SNSS)

Important Notes To Nominating Applicant

The Special Needs Savings Scheme (SNSS) caters to Persons with Special Needs (PSNs) who are nominated by their parents/ legal guardians to draw a fixed monthly payout from the parents'/ legal guardians' CPF savings upon their demise.
SNSS is administered by Special Needs Trust Company (SNTC), a wholly owned subsidiary of SG Enable (SGE).

Before proceeding, all applicants are encouraged to check if your child's disability status has already been verified by logging into SupportGoWhere your Singpass: https://supportgowhere.life.gov.sg/grants/pwdr/apply

If your child is above 21 years old and does not have Singpass, you may check by calling Operator (Bizlink): 64366635
or email: msfdisability@bizlink.org.sg

Application Form must be duly completed and signed by the nominating applicant. The following supporting documents must be submitted together with the application form to **Special Needs Savings Scheme (SNSS) via mail** – ***20 Lengkok Bahru, #01-01, Singapore 159053***, or email – *contactus@sgenable.sg*

Nominating Applicant Checklist

- ❑ Copy of NRIC (front and back)
- ❑ Copy of Legal Guardian Court Order, if nominating applicant is a legal guardian

PSN Checklist

- ❑ Copy of Birth Certificate and NRIC (front and back)
- ❑ **If your child's disability status has not been verified :**
  - ❑ Supporting document from the SPED school issued on the school's official letterhead stating that the PSN is currently attending or has previously attended the SPED school **or**
  - ❑ Disability Verification Form (DVF) completed by a Registered Healthcare Professional*

  **Please note that a submitted Disability Verification Form (DVF) does not mean that your child's disability status has been verified.*
- ❑ Copy of PR documents, if the PSN is a PR below 16 years old

Please read the **Terms of Consent** and **Points for Consideration** before signing and submitting the form.
The processing time is about 15 working days (excluding mailing time), provided all relevant documents are duly submitted.

An **eligibility letter** will be issued to the nominating applicant upon confirmation of the nominated PSN's eligibility for SNSS. The nominating applicant is then required to proceed to the Central Provident Fund (CPF) Board with this eligibility letter to make an SNSS nomination.

For any queries about SNSS, please call **1800-8585-885**. For CPF nominations, please call CPF Hotline: **1800-227-1188**.

Eligibility

1. The nominating applicant and nominated PSN must be Singapore Citizens or Singapore Permanent Residents (PR) at the time of application for the SNSS scheme.
2. The nominating applicant must be the parent or legal guardian of the nominated PSN.
3. The nominated PSN must be attending or have attended a SPED or have a permanent disability based on any one of the following:
   a. Physical Disability: Requires some assistance with at least 1 of the 6 Activities of Daily Living due to physical impairment
   b. Moderate visual impairment or worse in the better eye
   c. Moderate hearing loss or worse in the better ear
   d. Intellectual disability
   e. Autism

Proof of disability must be provided using the Disability Verification Form (DVF) completed by a relevant registered Healthcare professional.

SNTC (SNSS) Reference Number: **SNSS /** / /

Particulars of Nominating Applicant

Name :

NRIC : **Age** :

Address :

Gender : ❑ Male ❑ Female

Citizenship : ❑ Singaporean ❑ Singapore PR

Contact : (H)

(O)

(M)

Email :

Relationship to PSN

❑ **Father** ❑ **Mother**

❑ ***Legal Guardian (Please state)** :

**Court Order document is required.*

Particulars of PSN

Name :

NRIC : **Age** :

Gender : ❑ Male ❑ Female

Citizenship : ❑ Singaporean ❑ Singapore PR

❑ *Tick here if address is same as Nominating Applicant's*

Address :

Contact : (H)

(O)

(M)

Disability Type :

Email :

SNTC (SNSS) Reference Number: **SNSS /** / /

Declaration of Nominating Applicant

1. I declare that the information and statements provided above are true and to the best of my knowledge.
2. I have read and understood the attached **Terms of Consent** and agree that:
   a. This application signifies my consent to SNTC and SGE to obtain information from the doctor whom the PSN has consulted or the SPED that the PSN is attending/had attended or any parties deem related for the purposes of verifying the eligibility status of the PSN, and I authorise the doctor/related parties to release such information to SNTC and SGE.
   b. SNTC and SGE collect, share, and use the personal information provided by me and that obtained from the doctor/ related parties, for the following purposes:
      i) To determine my and/or the client's eligibility for services provided or to be provided by SNTC and/or SGE from time to time;
      ii) To perform the services and execute its obligations under the services that **I/the client am/is** subscribed to.
      iii) To provide me and/or the client with information relating to events and any services by SNTC and/or SGE;
      iv) For data analysis, evaluation and policy making
   c. The personal information may be shared with relevant organisations, including third party service providers for the above purposes, with suitable controls in place.
   d. SNTC and SGE may also disclose our information provided herein to relevant organisations for the purposes of this application and/or the administration and provision of any services and/or schemes provided or to be provided from time to time by SNTC, SGE, and/or relevant organisations.
   e. A photocopy of this form shall be treated as valid and binding as if it were the original.
   f. If I make any false statement or produce any document which I know to be false, my SNSS application will be rejected and/or any eligibility letter issued to me will be withdrawn.
   g. SNTC's role relating to this SNSS application is solely to assess whether I and the PSN are eligible to participate in SNSS based on the information available to SNTC and subject to the prevailing guidelines at the time of the application.
   h. SNTC and SGE shall neither be responsible nor answerable for the actions of relevant organisations that have a part in SNSS.
   i. I may in writing withdraw my consent for SNTC and/or SGE to use, collect or disclose the personal information which I have provided except that the right to withdraw such consent is not extended to any personal information provided by me to SNTC and/or SGE pursuant to any legal agreement with them. Such withdrawal request may affect their ability to continue providing its services to the PSN and me.

Name of Nominating Applicant	**Signature of Nominating Applicant**	**Date**

FOR OFFICIAL USE ONLY

Document Verification

- ❑ NRIC of Nominating Applicant
- ❑ NRIC of Nominee (PSN)
- ❑ Birth Certificate of Nominee (PSN)
- ❑ Others (please specify): _____
- ❑ Annex A: SPED Certification Letter
- ❑ Disability Verification Form (DVF) (If required)

Assessment by: For and on behalf of SNTC, SG Enable

Application is Eligible / Ineligible — Signature: _____

Disability is Permanent? Yes / No / NA — Name: _____ (dated)

Review by: For and on behalf of SNTC, SG Enable

Application is Supported / Not Supported — Signature: _____

Remarks _____ — Name: _____ (dated)

Approval by MSF (escalated on)

Application is Approved / Rejected — Name/Designation: _____ dated _____

Remarks _____

Eligibility Letter / Letter of Rejection mailed to Nominating Applicant by: _____ (dated)

Terms of Consent

a) Client refers to person for whom SNTC's service is intended to benefit. This includes the settlor and/or the beneficiaries of an SNTC Trust; applicants and nominees under the **Special Needs Savings Scheme**; and any other beneficiary of SNTC's future services. Client includes both potential clients and those who have already signed up for SNTC's services.

b) Personal information of the nominating applicant and PSN includes but is not limited to:

i) Personal data (includes name, NRIC number, address, age, gender, family, household structure)
ii) Financial data (includes income, insurance coverage, wills)
iii) Medical reports
iv) Special education certification
v) Other information provided for SNTC's evaluation and administration of its services

Personal information may relate to past, present or future matters.

c) "SNTC's Services" refers to the current and any future services provided by SNTC and SG Enable, including but not limited to:

i) Drawing up a care plan
ii) Special Needs Trust Service
iii) SNTC's trust set-up sponsorship scheme
iv) Special Needs Savings Scheme
v) Senior Trust Planning Service

d) "Relevant organisations" refers to organisations which are involved in the provision/ administration of SNTC's Services, including but not limited to the Public Trustee's Office, Ministry of Social and Family Development, Office of the Public Guardian and Central Provident Fund Board, Agency for Integrated Care, SG Enable.

e) "Third party service providers" includes but not limited to service providers which maintain SNTC's computer systems and software, auditors, lawyers, and consultants which SNTC or SG Enable may engage from time to time.

Points for Consideration

1. *Can your PSN child manage the fixed monthly payout on his/her own?*

The fixed monthly payout will be disbursed to your PSN child's bank account upon your demise. If he/she is a minor at the point of your demise, the payouts will be made to the legal guardian(s) until your child reaches 18 years of age.

For nominees who lack mental capacity and have donees or deputies appointed under the Mental Capacity Act, the payouts will be made to their donee or court-appointed deputy. To find out more about the Lasting Power of Attorney (LPA) or Deputyship, please visit the website of the **Office of Public Guardian**.

2. *Do you know if the monthly payout is sufficient to meet your PSN child's monthly expenses upon your demise?*

The minimum monthly payout under SNSS for each nominee is $250 from each nominating applicant. The payout amount indicated at the point of nomination can be adjusted by making a new nomination, but cannot be changed upon your demise. Your spouse may also provide for your PSN child through SNSS by submitting a separate application.

If the combined balance of your CPF accounts is less than a year's worth of payout at the point of your demise (e.g. for an indicated monthly payout of $250, a year's worth of payout is $250 x 12 = $3,000), the CPF savings will be disbursed to your PSN child as a lump sum instead. To accumulate more CPF savings to benefit your PSN child, you can top up your CPF accounts and/or opt not to receive your monthly CPF payouts under the Retirement Sum Scheme or CPF LIFE. Please enquire with **CPF Board** for more details on these options.

3. *Do you wish to provide for your PSN child's future medical expenses?*

SNSS provides you with the flexibility to arrange for the funds in your Medisave Account to be transferred to your PSN child's Medisave Account on a periodic basis, and the funds from your other CPF accounts (Ordinary Account, Special Account, and Retirement Account) to be disbursed in fixed monthly payouts to your child's bank account.

4. *Are there any other assets (e.g. via insurance/Will) you or your loved ones intend to leave behind for your PSN child to support his/her future financial needs?*

SNSS only caters for your CPF savings. If you have substantial assets outside of CPF meant for your PSN child, you may wish to explore setting up a Special Needs Trust to safeguard his/her financial interests. To find out more about the Special Needs Trust, please call **6278 9598** or visit **http://www.sntc.org.sg/**.

DISABILITY VERIFICATION FORM (DVF)

Important Notes

The Disability Verification Form (DVF) verifies a person's disability status. A person should get this form completed if they are applying for specific disability schemes under the Ministry of Social and Family Development (MSF).

Instructions to the Person Needing Verification:

- Persons who have previously enrolled in Special Education (SPED) schools and/or had their disability status verified when applying for eligible MSF disability schemes do **not** need to submit this form. Please check if you need to submit this form before proceeding. For more information on how to check your eligibility, please visit: enablingguide.sg/disability-verification.
- Please confirm the verification fees with the registered healthcare professional/clinic before proceeding, as fees may vary.

Instructions to Healthcare Professionals (HCPs):

- Ensure that all compulsory fields are completed, with any amendments endorsed by the HCP who completes this form. Failure to do so will result in the form being deemed incomplete and render this form void.
- A relevant HCP can complete this form. The relevant HCPs for each disability type are:
  1. **Physical Disability:**
     a. **Adults and Children 8 years and above:** Registered Doctor[1], Physiotherapist[2], Occupational Therapist[3], or Nurse[4].
     b. **Children below 8 years old[5]:** Registered Paediatrician.
  2. **Deafness/Hard-of-hearing:** Registered Ear, Nose, and Throat (ENT) Specialist or Audiologists registered with Society for Audiology Professionals Singapore (SAPS).
  3. **Visual Impairment**: Registered Ophthalmologist or Optometrist under full or conditional registration with the Optometrists and Opticians Board.
  4. **Intellectual Disability:** Registered Paediatrician, Psychiatrist, or Clinical/Educational Psychologist registered as members of Singapore Psychological Society (SPS) and Singapore Registry of Psychologists (SRP), and practising in public/private hospitals, social service agencies or private clinics.
  5. **Autism:** Registered Paediatrician, Psychiatrist, or Clinical/Educational Psychologist registered with SPS and SRP, and practising in public/private hospitals, social service agencies or private clinics.

Please note:

- Verification of disability status does not automatically qualify a person for disability schemes or services. Further scheme-specific criteria may apply.
- MSF and/or SG Enable reserve the right to make the final decision on the verification of disability status, and outcome of any application made.
- MSF and/or SG Enable may request further information for any investigations, checks or audits of this disability verification, disability schemes or other assistance schemes, and may make a police report or take legal action if any false information is provided in this application.

[1] Doctors with full or conditional registration issued by the Singapore Medical Council, and practising at the premises of a licensed healthcare institution under the Healthcare Services Act.

[2] Physiotherapists with full, conditional or restricted registration issued by the Allied Health Professions Council (AHPC).

[3] Occupational therapists with full, conditional or restricted registration (only "Physical dysfunction / Adults and older adults" classification) issued by AHPC.

[4] Registered nurses with full or conditional registration issued by the Singapore Nursing Board.

[5] Unless the child is bedridden, in which case 1(a) applies.

DISABILITY VERIFICATION FORM (DVF)

Section A: Patient's Particulars **(To be completed by the Healthcare Professional only)** All fields are compulsory.	
Name of Person Needing Verification:	NRIC/Birth Certificate No. of Person Needing Verification:

Section B: Verification of Disability Type **(To be completed by the Healthcare Professional only)** This field is compulsory.	
Verifying For *(Tick all that apply)*	☐ Physical Disability (Complete Section B1) ☐ Deafness / Hard-of-Hearing (Complete Section B2) ☐ Visual Impairment (Complete Section B3) ☐ Intellectual Disability (Complete Section B4) ☐ Autism (Complete Section B5)

Section B1: Verification of Physical Disability **(To be completed by a Registered Doctor / Physiotherapist / Occupational Therapist / Nurse only)** *Please refer to Circular No. 46/2025 for details on the verification of Physical Disability*	
(1) Does the Person Needing Verification have a specified condition? *(Note: Please refer to Circular No. 46/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)* **If yes,** please state the condition. **If no,** please leave blank and go onto **(2)**.	**Specified Condition:** _____ **Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY) _____/_____

Verification of Physical Disability continues on the next page

Section B1: Verification of Physical Disability

(To be completed by a Registered Doctor / Physiotherapist / Occupational Therapist / Nurse only)

Please refer to Circular No. 46/2025 for details on the verification of Physical Disability

(2) Please complete the ADL assessment below **only if the Person Needing Verification does not have a specified condition under (1) causing Physical Disability, or wishes to apply for MOH's ADL-based schemes:**

Activities of Daily Living (ADLs)[6]

Please complete the verification and ensure all six ADLs have been ticked accordingly.
If any of the ADLs are left blank, it will be taken that the Person Needing Verification is independent in performing the ADL.

	Requires help/supervision	Independent – No help is required
Mobility	☐	☐
Washing or Bathing	☐	☐
Dressing	☐	☐
Feeding	☐	☐
Toileting	☐	☐
Transferring	☐	☐

Please estimate when the Person Needing Verification first required assistance with the ADLs:

_____/_____ (MM/YYYY)

Indicate whether the need for assistance is required for 6 months or more from the date of assessment:

☐ Yes, required for 6 months or more from the date of assessment
☐ No, required for less than 6 months

Impairment affecting ADLs	If Person Needing Verification requires help/supervision with the ADLs, please indicate whether functional ability for the ADLs are predominantly affected by physical impairment, cognitive impairment, or both. ☐ Physical Impairment ☐ Cognitive Impairment ☐ Both Physical and Cognitive Impairment

If there is a known condition that gave rise to the need for assistance with ADLs, please state it here:

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[6] ***Activities of Daily Living (ADLs) are defined as follows:***

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.*

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.*

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

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

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.*

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.*

Section B2: Verification of Deafness / Hard-of-Hearing **(To be completed by a Registered ENT Specialist / Audiologist only)** *Please refer to Circular No. 47/2025 for details on the verification of Deafness / Hard-of-hearing* All fields are compulsory.	
Unaided hearing threshold in better ear *(Note: Please refer to Circular No. 47/2025 for the thresholds.)*	☐ No or better than mild hearing loss ☐ Mild*(Please refer to the circular) ☐ Moderate ☐ Moderate-Severe ☐ Severe ☐ Profound
Is the hearing loss long-term (i.e., will last 6 months or more from the date of the most recent assessment)?	☐ Yes ☐ No
Please estimate when the Person Needing Verification was first diagnosed with hearing loss (MM/YYYY)	*Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with hearing loss.*
If there is a known condition that gave rise to the hearing loss, please state it here:	

Section B3: Verification of Visual Impairment

(To be completed by a Registered Ophthalmologist / Optometrist only)

Please refer to Circular No. 48/2025 for details on the verification of Visual Impairment

(1) Does the Person Needing Verification have a specified condition? *(Note: Please refer to Circular No. 48/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)* **If yes,** please state the condition. **If no,** please leave blank and go onto **(2)**.	**Specified Condition:** _____ **Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY) _____/_____

(2) Please complete the section below **only if the Person Needing Verification does not have a specified condition under (1) causing Visual Impairment:**

Visual Assessment / **Severity of Visual Impairment**:

Please complete the verification and ensure all fields have been filled accordingly.

Visual Acuity in better eye with best possible correction *(Note: Please refer to Circular No. 48/2025 for the thresholds.)*	☐ No or mild visual impairment*(Please refer to the circular) ☐ Low vision ☐ Legally blind ☐ No light perception ☐ Not tested
Visual field in better eye with best possible correction	☐ Visual field > 20 degrees ☐ 11-20 degrees ☐ ≤10 degrees ☐ Not tested
Is the visual impairment long-term (i.e., will last 6 months or more from the date of the most recent assessment)?	☐ Yes ☐ No
Please estimate when the Person Needing Verification was first diagnosed with visual impairment (MM/YYYY)	*Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with visual impairment.*

If there is a known condition that gave rise to the visual impairment, please state it here:

Section B4: Verification of Intellectual Disability

(To be completed by a Registered Paediatrician / Psychiatrist / Clinical or Educational Psychologist only)

Please refer to Circular No. 49/2025 for details on the verification of Intellectual Disability

(1) Does the Person Needing Verification have a specified condition? *(Note: Please refer to Circular No. 49/2025 for the list of specified conditions. Please use the condition terminology as stated in the Circular.)* **If yes,** please state the condition. **If no,** please leave blank and go onto **(2)**.	**Specified Condition:** _____ **Please estimate when the Person Needing Verification was first diagnosed with the above condition** (MM/YYYY) _____/_____

(2) Please complete the section below **only if the Person Needing Verification does not have a specified condition under (1) causing Intellectual Disability and has a <u>confirmed</u> clinical diagnosis of Intellectual Disability**[7]:

Please complete the verification and ensure all fields have been filled accordingly.

Severity of Intellectual Disability[8]	☐ Mild Intellectual Disability ☐ Moderate Intellectual Disability ☐ Severe Intellectual Disability ☐ Profound Intellectual Disability ☐ Severity not specified
Please estimate when the Person Needing Verification was first diagnosed with Intellectual Disability (MM/YYYY)	*Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with intellectual disability.*

If there is a known condition that gave rise to the Intellectual Disability, please state it here:

[7] This should be a confirmed clinical diagnosis of intellectual disability that fulfils all criteria in the prevailing version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM; currently DSM-5) or the World Health Organisation's International Classification of Diseases (ICD; currently ICD-11).

[8] This should be completed based on the compositive severity (Intelligence Quotient (IQ) and Adaptive Functioning) if available; otherwise, it can be completed on the basis of IQ score.

Section B5: Verification of Autism

(To be completed by a Registered Paediatrician / Psychiatrist / Clinical or Educational Psychologist only)
All fields are compulsory.
Please refer to Circular No. 49/2025 for details on the verification of Autism

Please complete the section below **only if the Person Needing Verification has a <u>confirmed</u> clinical diagnosis of Autism**[9]:
Please complete the verification and ensure all fields have been filled accordingly.

Level of Support Needs	☐ Level 1 (i.e., "Requiring Support") ☐ Level 2 (i.e., "Requiring Substantial Support") ☐ Level 3 (i.e., "Requiring Very Substantial Support") ☐ Level not specified
Please estimate when the Person Needing Verification was first diagnosed with Autism (MM/YYYY)	*Note: Please indicate today's date if this form is being completed at the same time as the Person Needing Verification is being first diagnosed with autism.*

If there is a known condition that gave rise to Autism, please state it here:

[9] This should be a confirmed clinical diagnosis of autism that fulfils all criteria in the prevailing version of the DSM (currently DSM-5) or ICD (currently ICD-11), and in accordance with the diagnostic approaches recommended in the prevailing Clinical Practice Guidelines on Autism by the Academy of Medicine, Singapore. A confirmed clinical diagnosis of Asperger Syndrome will also be accepted. Clinicians should ensure additional supporting documents deemed necessary to verify a confirmed diagnosis are sighted.

Section C: Healthcare Professional's Declaration and Signature

Please tick one only:

☐ The Person Needing Verification is **not related to me.**

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

Declaration

I have assessed the Person Needing Verification and confirm the information indicated in Sections A and B of this form are true and correct to the best of my knowledge.

[For Doctors only] I/My organisation also possess(es) the necessary licence(s) including the relevant and valid Healthcare Services Act (HCSA) licence(s) to conduct and submit the DVF.

**Compulsory field*

Name of Healthcare Professional*	Registration No. of Healthcare Professional (where applicable)	Signature of Healthcare Professional*	Date of Completion of Form*

Contact Number of Healthcare Professional*	Email Address of Healthcare Professional	Institution Stamp*