

<b>REFERRAL FORM</b>		
<b>I AM AWARE THAT:</b>		
<input type="checkbox"/> SNTC only provides services for Singaporeans and Permanent Residents who are Persons with Special Needs (PSNs).		
<input type="checkbox"/> Referrals to SNTC can be made as long as the PSN is eligible for either SNTC Trust or Special Needs Saving Scheme (SNSS).		
<input type="checkbox"/> There is no obligation for caregivers to sign up for SNTC services even after an initial appointment with a Case Manager. A beneficiary care plan will be completed during the appointment and caregivers are free to bring it home for consideration.		
<input type="checkbox"/> SNTC does not provide monies to fund trust accounts. Caregivers are guided in earmarking their own assets (e.g. CPF savings, HDB flat) to fund the trust accounts for the long-term care needs of PSNs.		
<input type="checkbox"/> In sending us the details of the referred persons to <a href="mailto:contactus@sgenable.sg">contactus@sgenable.sg</a> , you confirm that we can disclose your name to them and you further confirm that you have obtained their consent for us to contact them via email, phone and/or SMS in accordance with the Personal Data Protection Act 2012.		
<b>1 REFERRAL DETAILS (To proceed only if the above boxes are checked)</b>		
Agency (if applicable)		
Name	Designation	
Contact No.	Email Address	
<b>2 PSN'S INFORMATION (To the best of your knowledge)</b>		
Name		
NRIC	Gender	Marital Status
Date of Birth	Race	Religion
Type of Disability <input type="checkbox"/> Alzheimer's Disease / Dementia <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Intellectual Disability / Global Developmental Delay <input type="checkbox"/> Learning Disability (Attention Deficit Hyperactive Disorder / Dyspraxia) <input type="checkbox"/> Multiple Disability, co-morbid conditions		
<input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Physical Disability <input type="checkbox"/> Mental Health Conditions (eg: Schizophrenia / Bipolar Disorder) <input type="checkbox"/> Others : _____		
<b>3 CAREGIVER'S INFORMATION (To the best of your knowledge)</b>		
Name		
NRIC	Gender	Marital Status
Date of Birth	Relationship to PSN	
Residential Address	Ownership of Property <input type="checkbox"/> Owned <input type="checkbox"/> Rented	
Educational Level	Employment Status / Occupation	
Health Condition	Monthly Household Income (Estimated)	
Mobile No. Residential No: Email:	Preferred Language Medium	
<b>4 FOR OFFICIAL USE</b>		
Assessed by:	Appointment Date:	