RARE DISORDERS SOCIETY SINGAPORE

Mailing Address : **Privy Box No. 920639 Singapore 929292**
Email Address : contact@rdss.org.sg
Contact No : 8088 9294
Website : www.rdss.org.sg

RARE DISORDERS SOCIETY (SINGAPORE)
APPLICATION FORM FOR THERAPY SUPPORT SUBSIDY

Closing date: 30 November (Refer to Financial Schemes Guide for more details)
The claim cap is temporary set to $2,700 for Year 2026 for consumed sessions
(for invoices dated 1 June 2025 to 30 November 2026)
Self Applicant must be 21 years old and above

SECTION A : APPLICANT'S PARTICULARS (must be a registered RDSS Beneficiary)

BENEFICIARY NAME (underline surname) : _____

DATE OF BIRTH (DD/MM/YYYY) : ____ / ____ / _____ AGE : ___ IDENTIFICATION NO : T / S X X X X __ __ __ __

GENDER : FEMALE / MALE RACE : _____ NATIONALITY : SINGAPORE / PERMENANT RESIDENT

MOBILE NO : _____ EMAIL ADDRESS : _____

RESIDENTIAL ADDRESS

BLK / NO : _____ UNIT NO : _____ POSTAL CODE : _____

STREET : _____

If applying the scheme on behalf of beneficiary, please fill up the following:

RELATIONSHIP TO THE BENEFICIARY : FATHER / MOTHER / GUARDIAN / SPOUSE

NAME OF PERSON SUBMITTING THE FORM (underline surname) : _____

MOBILE NO : _____ EMAIL ADDRESS : _____

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

If you are claiming for more than one therapy, please fill in additional therapist's details on Page 3.

NAME OF THERAPIST : _____

CLINIC'S NAME : _____

CLINIC'S ADDRESS : _____

CLINIC'S UEN NUMBER : _____ CLINIC'S CONTACT NUMBER : _____

FREQUENCY OF THERAPY : _____

SECTION B : ASSESSOR ENDORSEMENT

(ONLY MEDICAL DOCTOR, (MEDICAL) SOCIAL WORKER, HOMECARE / PALLIATIVE NURSING PERSONNEL CAN ENDORSE)

☐ I confirm that the assessment done for the above applicant is true and correct to my best knowledge.

☐ I am aware that the assessment for this application will serve as reference only.

☐ Rare Disorders Society (Singapore) 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 applicant.

ASSESOR NAME : _____ HEALTH INSTITUION : _____

DESIGNATION : _____ EMAIL ADDRESS : _____

CONTACT NO : _____

_____ SIGNATURE

_____ ORGANISATION NAME AND STAMP

_____ DATE

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RARE DISORDERS SOCIETY (SINGAPORE)
REIMBURSEMENT FORM FOR THERAPY SUPPORT SUBSIDY

BENEFICIARY NAME (underline surname) : _____

ITEM NO	INVOICE NUMBER	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		

TOTAL : _____

PLEASE SELECT YOUR PREFERRED REIMBURSEMENT MODE.

☐ BY PAYNOW (MOBILE NO THAT IS REGISTERED TO YOUR PAYNOW) : _____

REGISTERED PAYNOW NAME : _____

☐ BY BANK TRANSFER (BANK NAME & ACCOUNT NO.) : _____

BANK ACCOUNT HOLDER NAME: _____

NOTE :

(1) Reimbursement(s) can only be made payable to either parent of the beneficiary or the beneficiary himself/herself.

(2) Original application form, with supporting documents must be mailed to RDSS in order to receive the reimbursement.

(3) If you provide any information that is untrue, inaccurate, outdated or incomplete, or if RDSS have any reasonable grounds to suspect so, we reserved the right to reject or cancel your application and/or refuse any current or future application(s) for financial reimbursement(s).

(4) Latest date that RDSS has to receive the application form with the supporting documents : **30 November**

(5) Refer to the FAQ for more information about the THERAPY SUPPORT SUBSIDY

NAME OF PARENT APPLYING ON BEHALF FOR BENEFICIARY / NAME OF BENEFICIARY : _____

SIGNATURE : _____ **DATE : _____**

FOR RDSS INTERNAL USE (YOUR NAME AND SIGN OFF)	
CHECKED BY : _____ DATE :	APPROVED BY : _____ DATE :

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RARE DISORDERS SOCIETY (SINGAPORE)
DETAILS OF ADDITIONAL THERAPIST

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ______________________________

CLINIC'S NAME : ______________________________

CLINIC'S ADDRESS : ______________________________

CLINIC'S UEN NUMBER : ______________ CLINIC'S CONTACT NUMBER : ______________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ______________________________

CLINIC'S NAME : ______________________________

CLINIC'S ADDRESS : ______________________________

CLINIC'S UEN NUMBER : ______________ CLINIC'S CONTACT NUMBER : ______________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ______________________________

CLINIC'S NAME : ______________________________

CLINIC'S ADDRESS : ______________________________

CLINIC'S UEN NUMBER : ______________ CLINIC'S CONTACT NUMBER : ______________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ______________________________

CLINIC'S NAME : ______________________________

CLINIC'S ADDRESS : ______________________________

CLINIC'S UEN NUMBER : ______________ CLINIC'S CONTACT NUMBER : ______________

THERAPY SUPPORT DETAILS (COMPLIANCE CHECKS WILL BE DONE AT RANDOM)

NAME OF THERAPIST : ______________________________

CLINIC'S NAME : ______________________________

CLINIC'S ADDRESS : ______________________________

CLINIC'S UEN NUMBER : ______________ CLINIC'S CONTACT NUMBER : ______________