NATIONAL DEVELOPMENT FUND FOR PERSONS WITH DISABILITIES (NDFPWD)

APPLICATION FORM-PO/AP/1

ASSISTIVE DEVICES

SECTION A: PERSONAL DETAILS

1. NAME: ……..

2. GENDER: ❑ MALE ❑ FEMALE

3. DATE OF BIRTH: (DD/MM/YY) ……

4. NATIONAL ID NUMBER: ……..

5. DISABILITY IDENTIFICATION NUMBER……

6. A) POSTAL ADDRESS: ……CODE…… TOWN……..

   TELEPHONE: ……EMAIL: ……

   B) HOME PHYSICAL ADDRESS: LOCATION…… DIVISION……

   SUB-COUNTY ……. CONSTITUENCY …… COUNTY……

7. OCCUPATION/EMPLOYMENT OF APPLICANT (WHERE APPLICABLE): ……

8. IF APPLICANT IS UNDER 18 YEARS, NAME OF PARENT/GUARDIAN: ……

   NATIONAL ID. NO: …… RELATIONSHIP TO APPLICANT: ……

9. OCCUPATION/EMPLOYMENT OF PARENTS/GUARDIAN (WHERE APPLICABLE): ……

10. DISABILITY TYPE(S) (SPECIFY)… ……

11. PLEASE STATE IF YOU HAVE ANY SPECIAL COMMUNICATIONS REQUIREMENTS:

    ❑ TEXT ONLY ❑ SIGN LANGUAGE ❑ LARGE PRINT ❑ BRAILLE ❑ OTHER (SPECIFY) ……

SECTION B: ASSISTIVE DEVICE(S) REQUESTED

1. A) DO YOU HAVE ANY ASSISTIVE DEVICES CURRENTLY IN USE ❑ YES ❑ NO

   B) IF YES, STATE TYPE OF DEVICE……

   C) SOURCE OF DEVICE ❑ NDFPWD ❑ OTHER (SPECIFY)…… DATE RECEIVED……

2. ASSISTIVE DEVICE(S) REQUESTED

❑ WHEELCHAIR ❑ TRICYCLE ❑ CALIPERS ❑SURGICAL BOOTS

❑ CRUTCHES ❑ PROSTHESIS ❑ WALKING SUPPORT ❑ HEARING AID

❑ SPEECH AID ❑ BRAILLE DEVICE ❑ COMPUTER SOFTWARE (EG. JAWS ❑ WHITE CANE

❑ OTHER (SPECIFY) ……

3. IN WHICH WAY WILL THE DEVICE IMPROVE YOUR LIFE? (TICK AS APPLIES)

❑ MOBILITY ❑ COMMUNICATION ❑ HEALTH/REDUCE PAIN

❑ STUDY/ACCESS EDUCATION ❑ ABILITY TO WORK FOR INCOME ❑ SOCIAL LIFE

❑ INDEPENDENCE ❑ OTHER (PLEASE STATE) ……

SECTION C: PROFESSIONAL RECOMMENDATION ON THE APPROPRIATE ASSISTIVE DEVICE (S)

1. DESCRIBE THE APPLICANT'S NATURE OF DISABILITY

……

……

……

2. NAME OF SERVICE PROVIDER……

3. NAME OF RECOMMENDING OFFICER…… DESIGNATION……

RECOMMENDATION……

……

……

SIGNATURE AND STAMP: ……DATE: ……

SECTION D: DECLARATION

I HAVE ATTACHED THE FOLLOWING DOCUMENTS:

A) COPY OF NATIONAL IDENTIFICATION CARD (OF APPLICANT OR OF GUARDIAN IF APPLICANT IS UNDER 18YRS)

B) COPY OF DISABILITY IDENTIFICATION CARD TO CERTIFY DISABILITY

C) ORIGINAL PROFESSIONAL ASSESSMENT REPORT FOR THE APPROPRIATE ASSISTIVE DEVICE

I …… CERTIFY THAT THE INFORMATION PROVIDED ON THIS APPLICATION IS TRUE AND CORRECT.

SIGNATURE: .....DATE: ……..

SECTION F: FOR OFFICIAL USE – NCPWD COUNTY DISABILITY SERVICES OFFICER

NAME OF NCPWD COUNTY DISABILITY SERVICES OFFICER: …… COUNTY: ……

- ❑ I DO / DO NOT [DELETE AS APPROPRIATE] RECOMMEND THE FOLLOWING INDIVIDUAL TO NDFPWD FOR SUPPORT.

REASON FOR RECOMMENDATION/ REJECTION:

……

……

……

❑ I CONFIRM THAT I HAVE CHECKED ALL THE RELEVANT ATTACHMENTS ARE PRESENT AND CORRECT

SIGNATURE AND STAMP: …… DATE: ……

SECTION G: FOR OFFICIAL USE – NDFPWD – HEADQUARTERS

RECEIVED BY:

NAME OF OFFICER …… DESIGNATION……

SIGNATURE AND STAMP: …… DATE: …… REFERENCE NO: ……