Republika ng Pilipinas
LUNGSOD NG MAKATI

OFFICE OF THE MAYOR
MAKATI ACTION CENTER

Date:____________________

AUTHORIZATION

This is to authorize ____ of Barangay **BEL-AIR**, MAC Coordinator to submit my **PWD** Application to the Office of the Makati Social Welfare Department (MSWD) and facilitate its processing.

____
PRINTED NAME AND SIGNATURE

ADDRESS: _________________________
____
____

For MAC use only:

I. Qualifications:
1. Must be a Filipino Citizen
2. Must be a registered voter and
   Actual / current resident of the City of Makati for the past six (6) months or his/her parents or guardian.

REQUIREMENTS:
( ) Latest 6 pcs. 1x1 photo AND 1 pc 2x2 photo of Applicant
( ) Latest COMELEC CERTIFICATION (for minors-Voter Certificate of Parents/guardian are required)
( ) Birth Certificate (if minor)
( ) Duly accomplished PWD Profile Sheet
( ) Medical Certificate with Classification of Disability
( ) Certification of Disability signed by Brgy. Health Center Physician
( ) Barangay Clearance and Condo Certification *(for Salcedo, Malugay & Jazz Residents only)*
( ) Long Brown Envelope

Checked by: ______________________________________

CITY GOVERNMENT OF MAKATI
MAKATI SOCIAL WELFARE DEPARTMENT

Attach latest 1 x 1 photo here

REGISTRATION FORM FOR PWD IDENTIFICATION CARD APPLICATION

DATA PRIVACY CONSENT

In compliance with the **Data Privacy Act (DPA) of 2012**, I allow the Makati Social Welfare Department (MSWD) to collect and use my personal information in relation to my purpose of application for **PWD Identification Card**.

As such, I also agree and authorize them to:

1. Retain and store my information for a certain period of time as prescribed by law from the date of the accomplishment of the purpose stated above. I agree that my information will be deleted / destroyed after this period.
2. Share my information to other office / department within the City Government of Makati, I am assured that security systems are employed to protect my information.
3. I alone can view, change and recover the personal information I shared unless I authorize a representative on my behalf armed with a Special Power of Attorney duly notarized for this purpose. This applies also to any request for a certified true copy bearing any of my personal information.
4. Inform me of future programs, projects and services offered by the City Government of Makati using the personal information I shared.
5. I hold free and harmless and indemnify the City Government of Makati, any of its offices/departments, officers, employees and agents from any complaint, suit, or damages which any party may file or claim in relation to the Data Privacy Act.

Signed this _____day of __________________20___ at Makati City.

____
(Signature over Printed Name)

QUALIFICATIONS AND DOCUMENTARY REQUIREMENTS

A. Qualifications:

1. Must be a Filipino Citizen who is suffering from permanent or long-term disabilities as described in Republic Act 7277.
2. Must be a registered voter and actual / current resident of the City of Makati for the past six months or his/her parents or legal guardian.

B. Applicants must submit the following Documentary Requirements:

1. Six (6) copies of latest 1x1 pictures of PWD applicant.
2. Latest COMELEC Certification (for minor applicants, COMELEC Certification of parents or legal guardian)
3. Latest Barangay Certificate of Residency
4. Duly Accomplished PWD Profile Sheet
5. Medical Certificate with classification of disability or
6. Duly accomplished Certification of Disability signed by the Barangay Health Center Physician or Private Doctor.

Type of Application **Date of Application** ____ - ____ - ____ (month / day / year)

☐ New Applicant ☐ Renewal

PWD I.D. No.: ____________ - ______

Date Issued: ____ - ____ - ____ (month / day / year)

Client Category (please check appropriate box)

☐ 4Ps/MCCT Beneficiary ☐ Solo Parent ☐ Returning OFW
☐ Senior Citizen ☐ Pregnant Woman
☐ Lactating Mother ☐ MCG Employee
☐ Indigenous Person Dept.__________

A. TYPE OF DISABILITY

☐ Communication Disability
☐ Speech Impairment
☐ Hearing Impairment
☐ Learning Disability
☐ Intellectual Disability
☐ Orthopedic Disability
☐ Psychosocial/Mental Disability
☐ Visual Disability ☐ None

CAUSES OF DISABILITY

○ Inborn ○ Autism ○ Cancer
○ Injury-Related ○ Rare Disease
○ Acquired ○ Chronic Illness

REHABILITATION

○ *Community-Based*
○ *Institution-Based*
○ *None*

B. NAME OF APPLICANT

LAST NAME ______________________ EXTN. NAME ______

FIRST NAME ______________________

MIDDLE NAME ______________________

MAIDEN NAME *(if female)* ______________________

C. OTHER PERSONAL INFORMATION

My Own Gcash No.: ____ - ____ - ____

Landline Number: ____ - ____ - ____

Mobile Number: ____ - ____ - ____

OSCA I.D. Number: ______

BLU CARD I.D. No.: ______

MAKATIZEN ID Number: ______

Solo Parent I.D. Number: ______

SSS Number: ______

GSIS Number: ______

Philhealth Number: ______

Yellow Card Number: ______

Email Address: ______

Date of Birth: ____ - ____ - ____ (day / month / year)

Age: ____

Sex: ☐ Male ☐ Female

Civil Status: ☐ Single ☐ Married ☐ Common Law Relationship ☐ Legally Separated ☐ Divorced ☐ Annuled ☐ Widow/Widower

Nationality: ______

Blood Type: A+ | O+ | B+ | AB+ | A- | O- | B- | AB-

Place of Birth: ______ ______ (*City / Municipality*, *Province*)

Current Makati City address:

______ | ______ | ______ | ______ | ______
Rm./Flr./Unit No. & Bldg. Name | House/Lot & Blk. Nos. | Street | Barangay | City

D. SOCIO-ECONOMIC PROFILE

Tenurial Status:

○ Owner
○ Renter
○ Sharer
○ Boarder
○ Street Dweller

Living Arrangement:

○ Living with Parent(s), Sibling(s) & Dependent(s)
○ Living with Sibling(s) & Dependent(s)
○ Living with Parent(s) & Dependent(s)
○ Living with Dependent(s) only
○ Others:

Occupation: ______

Employer: ______

Employment Status:

☐ Employed
☐ Unemployed
☐ Self Employed: Nature of Business: ______

Type of Employment

☐ Regular ☐ Project Based
☐ Casual ☐ Seasonal

Category of Employment

☐ Private
☐ Government

Highest Educational Attainment:

○ SPED Level: ______
○ Elementary G1 | G2 | G3 | G4 | G5 | G6
○ High School G7 | G8 | G9 | G10 | G11 | G12
○ Non-Graduate
○ College 1st Yr. | 2nd Yr. | 3rd Yr. | 4th Yr. | 5th Yr. | Graduate
○ Masteral ☐ Graduate ☐ Undergraduate ○ None
○ Doctoral ☐ Graduate ☐ Undergraduate
○ Vocational: ______

Total Monthly Income Including Other Sources:

☐ A-5,000 below ☐ B-5, 001 - 10, 000 ☐ E-20, 001 above
☐ C-10,001-15,000 ☐ D-15, 001 - 20, 000 ☐ F-None

HEALTH AND SOCIAL WELFARE SERVICES

Assistance Needed:	Nat'l. Gov't.	LGU Makati	NGO's
Medical	☐	☐	☐
☐ medicines	☐	☐	☐
☐ hospitalization	☐	☐	☐
Education	☐	☐	☐
☐ Tuition Fee Subsidy	☐	☐	☐
☐ Allowence	☐	☐	☐
☐ Braille Materials	☐	☐	☐
Shelter Subsistence	☐	☐	☐
☐ Food etc..	☐	☐	☐
Livelihood	☐	☐	☐
☐ Capitalization	☐	☐	☐
☐ Skills Training	☐	☐	☐
Assistive Devices	☐	☐	☐
☐ Wheel Chair	☐	☐	☐
☐ Crutches	☐	☐	☐
☐ Cane	☐	☐	☐
☐ Prosthesis	☐	☐	☐
☐ Hearing Aid	☐	☐	☐
☐ Job Placement/Employment	☐	☐	☐
☐ Social/Vocational Rehab.	☐	☐	☐
☐ PWD Tranport Plus	☐	☐	☐
☐ Free Movie ID	☐	☐	☐
☐ Yellow Card	☐	☐	☐
☐ Philhealth	☐	☐	☐
☐ Training on Home Management	☐	☐	☐
☐ Others:	☐	☐	☐
☐ None	☐	☐	☐

Sports and Recreational Activity

- ☐ Athletics
  - ☐ Running
  - ☐ Javelin Throw
  - ☐ Shot-put
- ☐ Basketball
- ☐ Wheelchair Basketball
- ☐ Volleyball
- ☐ Badminton
- ☐ Swimming
- ☐ Table Tennis
- ☐ Power Lifting
- ☐ Chess
- ☐ Goalball
- ☐ Gymnastics
- ☐ Tenpin Bowling
- ☐ Football
- ☐ Bocce/Boccia
- ☐ Others:

Type of Acquired Skills

- ☐ Artificial Leg Making
- ☐ Basket Making
- ☐ Cake Decoration
- ☐ Carpentry
- ☐ Cooking
- ☐ Cosmetology
- ☐ Crochet Work/Embroidery
- ☐ Digital Arts
- ☐ Drawing Dress Making
- ☐ Driving
- ☐ Electrical Works
- ☐ Electronic Works
- ☐ Floral Arrangement
- ☐ Gardening
- ☐ Mechanical Works
- ☐ Painting
- ☐ Photography
- ☐ Refelexology
- ☐ Silkscreen Painting
- ☐ Technician
- ☐ Computer Trouble Shooti
- ☐ Typing/Encoding
- ☐ Welding
- ☐ None
- ☐ Others:

YOUTH CATEGORIZATION

☐ In-School ☐ Working Youth ☐ Out of School ☐ Non-working Youth

ORGANIZATIONAL AFFILIATION

Affiliation: ______

Position: ______

Contact Person: ______

Office Address: ______

Tel. Nos. ______

APPLICANT'S FAMILY COMPOSITION

Name (First Name, Middle Name, Last Name)	Relationship to Applicant	Civil Status	Age	Sex	Educational Attainment	Occupation / Monthly Income	Living with the Applicant? YES	Living with the Applicant? NO	PWD	Solo Parent	Seni Citiz
							☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐
							☐	☐	☐	☐	☐

DECLARATION

I certify that the information provided in this form are true and correct. Any false information shall cause the disapproval or revocation of my PWD ID.

Printed Name and Signature of Applicant

Date: month / day / year

IF CANNOT SIGN, PLEASE AFFIX APPLICANT'S FINGERPRINT (Right Thumbmark)

Person to Notify in Case of Emegency:

LAST NAME

FIRST NAME

MIDDLE NAME EXTN. NAME

MAIDEN NAME (if female)

Relationship to Applicant: Contact Number:

Email Address:

FOR MAKATI ACTION CENTER (MAC) USE ONLY

This is to acknowledge the receipt of the validated and complete documentary requirements of the herein PWD Identification Card Applicant Mr/Ms./Mrs.:

______ (Print Name and Signature) Date: month / day / year

MAC Coordinator

TO BE FILLED OUT BY MSWD - PWD Welfare Section (PWDWS)

Received by:	Reviewed by:	Encoded by:
Signature above printed name	Signature above printed name	Signature above printed name
DATE:	DATE:	DATE:
TIME:	TIME:	TIME:

Recommending Approval:

Staff-In-Charge,MSWD-PWDWS / Head-PDAO

Approved by:

BENITA C. TANYAG
Acting City Government Assistant Department Head II

CERTIFICATION OF DISABILITY

MAKATI
SOCIAL
WELFARE
DEPARTMENT

This is to certify that (________________________), resident of (____________________), of the province of (____________________), in the region of (________________), had voluntarily submitted herself/himself to this facility/clinic/office with regard to the nature of disability due to the functional limitation currently experienced by the herein patient.

Based on the personal interview and medical assessment conducted by herein physician, the patient has (________________________) accompanied by (______________________)
(*diagnosis*) (*effect of illness*)
which results to difficulty in (____________________) and therefore considered as person with (___________________________) as classified by the Department of Health
(*type of disability*)
Administrative Order No. 2009-011.

This certification is issued on (______________) at (______________) in compliance with the requirement in the issuance of ID for the twenty percent (20%) discount for persons with disabilities mandated by Republic Act No. 9442 of Magna Carta for Persons with Disabilities.

Signed:

____
Name and Signature of Physician
License number: _________________
Contact number: _________________
Clinic address: ___________________

Note: FOR DOCTOR'S MEDICAL ASSESSMENT and PLEASE ATTACH MEDICAL CERTIFICATE

-See types of disability and definition at the back for your ready reference

TYPE OF DISABILITY

☐ **Psychosocial Disability**
☐ **Mental Disability**

☐ Bipolar
☐ Schizophrenia
☐ Acquired Mentally Retardation
☐ Severe Depression
☐ Generalized Anxiety

☐ **Learning Disability**

☐ Global Developmental Delay
☐ Slow Learner

☐ **Deaf (Hearing Loss)**
☐ **Speech and Language Impairment**

☐ Hearing Impairment

☐ **Visual Disability**
☐ Total Visual Impairment (Left)
☐ Total Visual Impairment (Right)
☐ Total Visual Impairment (Both)
☐ Partial Visual Impairment (Left)
☐ Partial Visual Impairment (Right)
☐ Partial Visual Impairment (Both)

☐ **Cancer (RA 11215)**

☐ **Rare Disease**

☐ **Intellectual Disability**
☐ Autism
☐ Down Syndrome
☐ ADHD
☐ Mental Retardation
☐ Acquire Lesions of the Central Nervous system
☐ Dementia
☐ Non- Psychotic Disorder

☐ **Orthopedic Disability**
☐ Weak, Paralyzed Left Leg
☐ Weak, Paralyzed Right Leg
☐ Weak, Paralyzed Both Legs
☐ Underdeveloped Left Leg
☐ Underdeveloped Right Leg
☐ Underdeveloped Both Legs
☐ Missing Left Leg
☐ Missing Right Leg
☐ Missing Both Legs
☐ Missing Left Foot
☐ Missing Right Foot
☐ Missing Both Feet
☐ Weak, Paralyzed Left Arm
☒ Weak, Paralyzed Right Arm
☐ Weak, Paralyzed Both Arms
☐ Underdeveloped Left Arm
☐ Underdeveloped Right Arm
☐ Underdeveloped Both Arms
☐ Missing Left Arm
☐ Missing Right Arm
☐ Missing Both Arms
☐ Missing Left Hand
☐ Missing Right Hand
☐ Missing Both Hands
☐ Missing Left Arm
☐ Missing Right Arm
☐ Cerebral Palsy
☐ Hunchback

CAUSES OF DISABILITY

☐ Inborn
☐ Illness / Disease
☐ Injury – Related
☐ Armed Conflict
☐ Accident
☐ Environmental Cause

REHABILITATION

☐ Community - Based
☐ Institution - Based
☐ None

DEFINITIONS OF TYPES OF DISABILITY

1. **Deaf (Hearing Loss)**- refers to people with hearing loss, implies or no hearing
   a. **Hearing Impairment** is a total or partial loss of hearing impairments functions which impedes the communication process essential to the language, educational, social and/or cultural interaction.
   b. **"Speech and language impairments"** means one or more speech/ language disorder of voice, articulation, rhythm and/ or receptive and expressive process of language.

2. **Learning Disability** - is any disorder in one or more basic psychological processes (perception, comprehension, thinking etc.) involved in the understanding or in using spoken or written language.

3. **Intellectual Disability** – is a disability resulting from organic brain syndrome (i.e. mental retardation, acquire lesions of the central nervous system, dementia and or non-psychotic disorder).

4. **Orthopedic Disability** – is a disability in the normal functioning of the joints, muscles and limbs.

5. **Mental Disability**- disability resulting from organic brain syndrome and or mental illness(psychotic or non-psychotic)

5. **Psychosocial Disability** – is define as any acquired behavioral, cognitive emotional or social impairment that limits one or more activities necessary for effective interpersonal transactions and other civilizing process or activities for daily living such as but not limited to deviancy or anti-social behavior.

6. **Visual Disability** – is one who has impairment of visual functioning even after treatment and/ or standard refractive correction, and has visual acuity in the better eye or less than (6/18 for low vision and 3/60 for blind), or a visual of less than 10 degrees from the point of fixation. A certain level of visual impairment is defined as legal blindness. One is legally blind when your best corrected central visual acuity in your better eye is 6/60 or worse or your side vision is 20 degrees or less in the better eye.

7. **Cancer (RA 11515)** refers to genetic term for a large group of disease that can affect any part of the body.

8. **Rare Disease (RA10747)** – refers to disorder as in inherited metabolic disorders and other disease with similar rare occurrence as recognized by the DOH upon recommendation of the NIH but excluding catastrophic.

DEPARTMENT OF HEALTH

Philippine Registry For Persons with Disabilities Version 4.0

Application Form

1. O NEW APPLICANT O RENEWAL *

Place 1"x1" Photo Here

2. PERSONS WITH DISABILITY NUMBER (RR-PPMM-BBB-NNNNNNN) *

3. DATE APPLIED: * (mm/dd/yyyy)

4. PERSONAL INFORMATION *

LAST NAME: *	FIRST NAME: *	MIDDLE NAME: *	SUFFIX: *

5. DATE OF BIRTH: * (mm/dd/yyyy)

6. SEX: * O MALE O FEMALE

7. CIVIL STATUS: *

O Single O Separated O Cohabitation (live-in) O Married O Widow/er

8. TYPE OF DISABILITY: *

- ☐ Deaf or Hard of Hearing
- ☐ Intellectual Disability
- ☐ Learning Disability
- ☐ Mental Disability
- ☐ Physical Disability(Orthopedic)
- ☐ Psychosocial Disability
- ☐ Speech and Language Impairment
- ☐ Visual Disability
- ☐ Cancer(RA11215)
- ☐ Rare Disease(RA10747)

9. CAUSE OF DISABILITY: *

- ☐ Congenital / Inborn
  - ☐ ADHD
  - ☐ Cerebral Palsy
  - ☐ Down Syndrome
  - ☐ Others, Specify:______
- ☐ Acquired
  - ☐ Chronic Illness
  - ☐ Cerebral Palsy
  - ☐ Injury
  - ☐ Others, Specify:______

10. RESIDENCE ADDRESS *

House No. and Street:*	Barangay:*	Municipality:*	Province:*	Region:*

11. CONTACT DETAILS

Landline No.:	Mobile No.:	E-mail Address:

12. EDUCATIONAL ATTAINMENT: *

- O None
- O Kindergarten
- O Elementary
- O Junior High School
- O Senior High School
- O College
- O Vocational
- O Post Graduate

13. STATUS OF EMPLOYMENT: *

- O Employed
- O Unemployed
- O Self-employed

13 b. TYPES OF EMPLOYMENT: *

- O Permanent / Regular
- O Seasonal
- O Casual
- O Emergency

13 a. CATEGORY OF EMPLOYMENT: *

- O Government
- O Private

14. OCCUPATION: *

- O Managers
- O Professionals
- O Technicians and Associate Professionals
- O Clerical Support Workers
- O Service and Sales Workers
- O Skilled Agricultural, Forestry and Fishery Workers
- O Craft and Related Trade Workers
- O Plant and Machine Operators and Assemblers
- O Elementary Occupations
- O Armed Forces Occupations
- O Others, specify: ______

15. ORGANIZATION INFORMATION:

Organization Affiliated:	Contact Person:	Office Address:	Tel. Nos.:

16. ID REFERENCE NO.:

SSS NO.:	GSIS NO.:	PAG-IBIG NO.:	PSN NO.:	PhilHealth NO.:

17. FAMILY BACKGROUND:	LAST NAME	FIRST NAME	MIDDLE NAME
FATHER'S NAME:			
MOTHER'S NAME:			
GAUARDIAN'S NAME :			

18. ACCOMPLISHED BY: *	LAST NAME	FIRST NAME	MIDDLE NAME
O APPLICANT			
O GUARDIAN			
O REPRESENTATTIVE			
19. NAME OF CERTIFYING PHYSICIAN: LICENSE NO.:			
20. PROCESSING OFFICER: *			
21. APPROVING OFFICER: *			
22. ENCODER: *			

23. NAME OF REPORTING UNIT(OFFICE/SECTION) :*

24. CONTROL NO.: *

Revised as of August 1, 2021

FOR SCANNING TO PVC PWD I.D.

Name ____

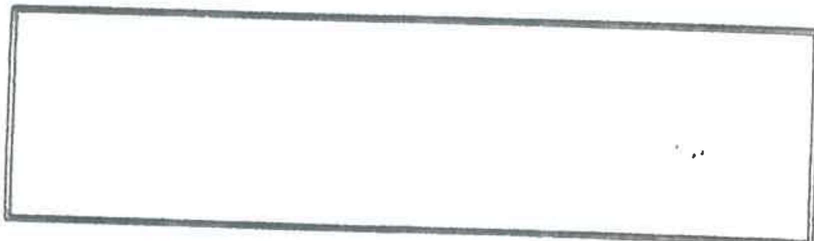
FIRST NAME , MIDDLE INITIAL, SURNAME

(Please use capital letters)

Address ____

HOUSE NO. STREET BARANGAY CITY

please place latest 2x2 I.D.picture inside the box



Signature or thumbmark inside the box

For PDAO Personnel only:

PWD I.D. Number ______________________________

Checked /scanned by: ____________________ Date ______________

Position : ____________________

Approved by : **MARITES Z. ESTANISLAO**

Head , PDAO