



GUIDELINES FOR THE ISSUANCE OF PWD NATIONAL ID

I.

Who May Avail

Any person who is:

1. A Filipino Citizen
2. Registered Voter; and
3. Resident of Makati

III.

Requirements

1. Three (3) copies - 1x1 pictures
2. Latest COMELEC Certification (for minors, submit the parent's COMELEC Certification)
3. Barangay Certification
4. Duly Accomplished PWD Application Form (PDAO Form 01-2022)
5. Certification of Disability signed by the Physician (PDAO Form 02-2022)
6. Medical Certificate with classification of disability issued by the Physician

III.

How to Avail

1. Secure application form from the Makati Action Center (MAC) Satellite Office located in your barangay. Submit together with the necessary documents to the same office.
2. Person with Disability Affairs Office (PDAO), Makati Social Welfare Department (MSWD) will process the application
3. Approved PWD National ID will be delivered to the house of the applicant by MAC together with Purchase Booklet, Medicine Booklet

IV.

Disapproval, Loss, and Forfeiture

1. MAC shall receive disapproved application and shall inform the applicant
2. In case of Lost Card, an affidavit of loss shall be submitted
3. The card shall be forfeited on the following reasons:
 - a) Transfer of residence;
 - b) Usage of the PWD ID by any person other than the Card Holder; and
 - c) Faked or counterfeited ID.

V.

Validity

The card will be valid for five (5) years

For follow up, please call PDAO at 8870 - 1630



CITY GOVERNMENT OF MAKATI
MAKATI SOCIAL WELFARE DEPARTMENT
PERSONS WITH DISABILITY AFFAIRS OFFICE (PDAO)



Attach latest
1 x 3 photo
here

PWD IDENTIFICATION CARD APPLICATION FORM

DATA PRIVACY CONSENT

In accordance with the Data Privacy Act of 2012 (DPA), and its Implementing Rules and Regulations (IRR) effective since September 8, 2016, I allow the Makati Social Welfare Department (MSWD) of the City Government of Makati to provide me certain services in relation to my application for PWD Identification Card.

As such, I agree and authorize them to:

1. Collect and use my personal information for the purpose stated above and for whatever legal purposes it may be intended for.
2. 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.
3. Share my information to other office/departments within the City Government of Makati and necessary third parties for any legitimate purpose. I am assured that security systems are employed to protect my information.
4. 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.
5. Inform me of future services or projects offered by the City Government of Makati using the personal information I shared.

Signed this ____ day of ____ 20__ in Makati City.

(Signature over Printed Name)

QUALIFICATIONS AND DOCUMENTARY REQUIREMENTS

A. Qualifications:

1. Must be a Filipino Citizen who are suffering from permanent or long-term disabilities as described in Republic Act 7277.
2. Must be a registered voter or 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. Three (3) copies of latest 1x1 pictures of PWD applicant.
2. Latest COMELEC Certification (for minor applicants, COMELEC Certification or Voter's ID of parents or legal guardian)
3. Latest Barangay Certificate of Residency
4. Duly Accomplished PWD Profile Sheet (PDAO Form 01-2022)
5. Medical Certificate with classification of disability
6. Duly accomplished Certification of Disability signed by the Barangay Health Center Physician or Private Doctor (PDAO Form 02-2022)

Type of Application Date of Application

☐ New Applicant ☐ Renewal

PWD I.D. No.: _____ month _____ day _____ year

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

☐ Speech Impairment	☐ Intellectual Disability
☐ Deaf or Hard of Hearing	☐ Orthopedic Disability
☐ Learning Disability	☐ Psychosocial Disability
☐ Mental Disability	☐ Cancer (RA11215)
☐ Visual Disability	☐ Rare Disease (RA10747)
	☐ 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 I.D. No.: _____

Solo Parent I.D. No.: _____

SSS Number: _____

GSIS Number: _____

Philhealth Number: _____

Yellow Card Number: _____

Email Address: _____

Current Makati City address: _____

Date of Birth: _____ month _____ day _____ year

Age: _____

Sex: ☐ Male ☐ Female

Civil Status: ☐ Single ☐ Married ☐ Common Law Relationship

☐ Widow/er ☐ Legally Separated ☐ Divorced ☐ Annulled

Blood Type: _____

Place of Birth: _____

City/ Municipality _____ Province _____

Rm./Flr./Unit No. & Bldg. Name

House/Lot & Bldg. Nos.

Street

Barangay

City

D. SOCIO-ECONOMIC PROFILE

Tenurial Status: Living Arrangement:

- ☐ Owner ☐ Living with Parent(s), Sibling(s) & Dependent(s)
- ☐ Renter ☐ Living with Sibling(s) & Dependent(s)
- ☐ Sharer ☐ Living with Parent(s) & Dependent(s)
- ☐ Boarder ☐ Living with Dependent(s) only
- ☐ Street Dweller ☐ Others:

Employment Status:

- ☐ Employed ☐ Regular ☐ Project Based ☐ Private
- ☐ Unemployed ☐ Casual ☐ Seasonal ☐ Government
- ☐ Self Employed: Nature of Business: _____

Type of Employment

Nature of Employment

Vocational:

- ☐ Graduate ☐ Undergraduate
- ☐ Graduate ☐ Undergraduate

Highest Educational Attainment:

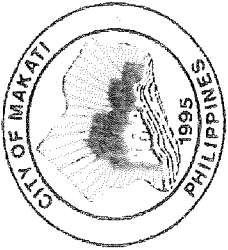
- ☐ Elementary ☐ G1 ☐ G2 ☐ G3 ☐ G4 ☐ G5 ☐ G6
- ☐ High School ☐ G7 / 1st ☐ G8 / 2nd ☐ G9 / 3rd ☐ G10 / 4th ☐ G11 ☐ G12
- ☐ College ☐ 1st Yr. ☐ 2nd Yr. ☐ 3rd Yr. ☐ 4th Yr. ☐ 5th Yr. ☐ Graduate
- ☐ Masteral ☐ Graduate ☐ Undergraduate ☐ None
- ☐ Doctoral ☐ Graduate ☐ Undergraduate

Total Monthly Income Including Other Sources:

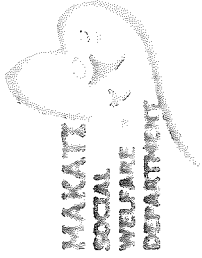
- ☐ A-5,000 below ☐ B-5,001 - 10,000 ☐ C-10,001-15,000 ☐ D-15,001 - 20,000 ☐ E-20,001 above
- ☐ F-None

Occupation:

Employer:



CERTIFICATION OF DISABILITY



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	☐ 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)		
☐ Learning Disability ☐ Global Developmental Delay ☐ Slow Learner	☐ Cancer (RA 11215) ☐ Rare Disease		
☐ Deaf (Hearing Loss) ☐ Speech and Language Impairment ☐ Hearing Impairment	☐ Intellectual Disability ☐ Autism ☐ Down Syndrome ☐ ADHD ☐ Mental Retardation ☐ Acquire Lesions of the Central Nervous system ☐ Dementia ☐ Non-Psychotic Disorder		
CAUSES OF DISABILITY		REHABILITATION	
☐ Inborn ☐ Illness / Disease ☐ Injury – Related ☐ Armed Conflict ☐ Accident ☐ Environmental Cause		☐ Community - Based ☐ Institution - Based ☐ None	

DEFINITIONS OF TYPES OF DISABILITY

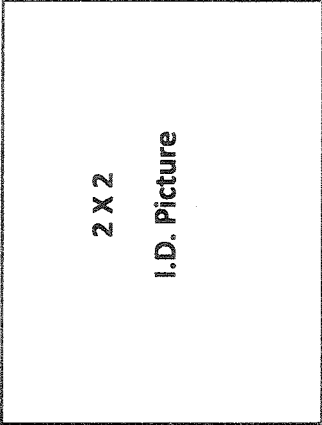
- Deaf (Hearing Loss)-** refers to people with hearing loss, implies or no hearing
 - Hearing Impairment is a total or partial loss of hearing impairments functions which impedes the communication process essential to the language, educational, social and/or cultural interaction.
 - “Speech and language impairments” means one or more speech/ language disorder of voice, articulation, rhythm and/ or receptive and expressive process of language.
- 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.
- 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).
- Orthopedic Disability** – is a disability in the normal functioning of the joints, muscles and limbs.
- Mental Disability-** disability resulting from organic brain syndrome and or mental illness(psychotic or non-psychotic)
- 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.
- 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.
- Cancer (RA 11515)** refers to genetic term for a large group of disease that can affect any part of the body.
- 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.

MAKATI SOCIAL WELFARE DEPARTMENT
PERSONS WITH DISABILITIES AFFAIRS OFFICE

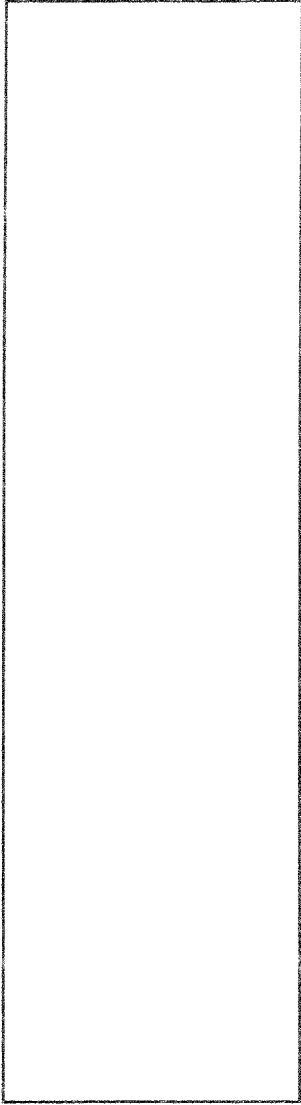
FOR SCANNING TO PVC PWD I.D. CARD

Name _____
FIRST NAME, MIDDLE INITIAL, SURNAME
(Please accomplish in printed letter – format use capital letters)

Address _____
HOUSE NO. STREET BARANGAY



please paste latest 2x2 ID picture inside the box



For signature at the PWD I.D.
please affix signature of if not applicable, put thumb mark inside the box

For PDAO Personnel only:

PWD I.D. NO. _____
Checked/Scanned by: _____ Date: _____
Position: _____

Approved by: _____
PDAO, Head

