Republic of the Philippines
Office of the President

PHILIPPINE CHARITY SWEEPSTAKES OFFICE

Sun Plaza Building, 1507 Shaw Boulevard corner Princeton St., Mandaluyong City 1152
www.pcso.gov.ph

MEDICAL ASSISTANCE PROGRAM (MAP)
APPLICATION FORM

REFERENCE NO.: ____________________
PETSA *(Date)*: ______mm/dd/yyyy______

Sagutan ang lahat ng patlang at lagyan ng tsek "✓" ang angkop nasagot. *(Fill up all the blank spaces and check the answer that applies.)*

1. ☐ **BAGONG APLIKANTE** *(New Applicant)* ☐ **DATING APLIKANTE** *(Old Applicant)*

2. **BUONG PANGALAN NG PASYENTE** *(Full Name of Patient)*

____
APELYIDO *(Surname)* **PANGALAN** *(Given name)* **GITNANG PANGALAN** *(Middle name)*

3. **TIRAHAN** *(Address)*

☐ **Permanente** *(Permanent)* ____
No. Street. Brgy. Municipality/City Province Region

☐ **Pansamantala** *(Temporary)* ____
No. Street. Brgy. Municipality/City Province Region

5. **PETSA NG KAPANGANAKAN** ____________ *(Birth Date)* mm/dd/yyyy   6. **EDAD** ______ *(Age)*   7. **KASARIAN:** *(Sex)* ☐ **Lalake** ☐ **Babae**

6. **NATIONALITY** ____________________   9. **RELIGION** *(Relihiyon)* ____________________

8. **IBA PANG PINAGKAKAKITAAN** *(OTHER SOURCES OF INCOME)*

Sources within the household ____________   Sources outside the household ____________
Total Monthly Income ____________   Total Monthly Income ____________

9. **MIYEMBRO NG PHILHEALTH?** ☐ **Member** ☐ **Dependent** ☐ **Non-Member**

10. **DIAGNOSIS**

____

11. **HINIHINGING TULONG:** *(Nature of Requested Assistance)* ☐ **In-Patient** ☐ **Out-Patient**

☐ **PAGPAPA-OSPITAL** *(Confinement)*

☐ **GAMOT** *(SPECIALTY MEDICINES):* SPECIFY: ____________

☐ **DIALYSIS:** ___**EPOETIN INJECTION**
___**HEMODIALYSIS TREATMENT**

☐ **LABORATORY/DIAGNOSTIC PROCEDURE**
TUKUYIN *(PLS. SPECIFY)* ____________________

☐ **CANCER TREATMENT:**
____**CHEMODRUGS**
____**RADIATION THERAPY**

☐ **MEDICAL DEVICE (PACEMAKER, STENT, SEPTAL OCCLUDER VALVES , VP –SHUNT, ETC.)**

☐ **ORTHOPEDIC (BONE) IMPLANT**

☐ **TREATMENT/PROCEDURES FOR CATASTROPHIC ILLNESSES**

____ **Kidney Transplant**
____ **Liver Transplant**
____**Coronary Artery By-pass Graft (CABG) surgery**

12. **KUNG DATING APLIKANTE:**

URI, HALAGA NG TULONG AT KAILAN NATANGGAP ITO MULA SA PCSO *(Type and Amount of Previous Assistance and Date Received)*

Uri ng Tulong *(Nature of Request)*	**Halaga** *(Amount)*	**Petsa** *(Date Received)*

Pinatutunayan ko na ang lahat ng inilahad ko dito ay pawing totoo at tama ayon sa aking kaalaman at kakayahan. Nababatid at naiintindihan ko na anumang maling impormasyon na aking sadyang ibinigay ay maaaring maging dahilan na hindi mapagbigyan ang aking kahilingan at maging dahilan sa paghabla ng kasong ligal laban sa akin. *(I hereby certify that all the information as stated above are true and correct based on my knowledge and capacity. I understand that any falsehood stated here may result in the rejection of my request and the filing of legal charges against me.)*

NOT FOR SALE

____

Lagda o Thumbmark ng Aplikante sa Itaas ng Pangalan
Signature or Thumbmark Above Applicant's Printed Name

ID na Ipinakita *(Valid ID presented)* ___________________________________

Kung walang ID, Sertipikasyon/Pruweba ng Pagkakakilanlan
*In lieu of ID, Certification/Proof of Identity*___________________________________

Kung kinatawan, Relasyon sa Pasyente *(Relation to Patient)* ____________________

Numerong Telepono*(Contact No.)* ___________________________________

Email Address ____

VALIDATED BY:

____
Medical Social Worker

The patient is hereby recommended assistance in the amount of (in words)
________________________________(P_______________) for____payable
to____.

REVIEWED AND EVALUATED BY: _____________________________
Name and Signature of PCSO Social Worker

APPROVED BY:

____

-------------------------------------- *For Assistance Above the Approving Authority/Beyond the Budget:* ---

RECOMMENDING APPROVAL:

____

APPROVED BY:

____