APPLICATION FORM

FREE DISTRIBUTION ONLY

(PUBLIC ASSISTANCE MEDICAL/ECONOMICAL)

Use Block Letters Only
Ministry of Human Services & Social Security *(To be sent to MISU)*

APPLICANT DATA

First Name:	……	Sex:	……
Middle Name:	……	Date of Birth:	……
Surname:	……	ID Card #:	……
Other Name:	……	Passport #:	……
Current Address:	……	Region:	……
	……	District:	……

Phone numbers: Landline ……. Cell: …….

CLAIMED SERVICE Application Date: ……

☐ Public Assistance - Medical ☐ Public Assistance - Economical

I declare that all the responses on this form are true and correct to the best of my knowledge and belief.

……. ……
Applicant signature/mark Date

……. ……
Receiving Officer's signature Date

✂……..

Ministry of Human Services & Social Security *(To be given to the Applicant)*

Full Name: …….. ID/PP #: ……..

CLAIMED SERVICE

☐ Public Assistance - Medical ☐ Public Assistance - Economical

Application Date: ……

Probation & Social Services Officer Name: …….. Signature: ……

Date: …….

PUBLIC ASSISTANCE MEDICAL INQUIRY/ REVIEW

GMO/ Medex,
Please examine applicant and report same for Poor Law Commissioners (PLC)/ Local Board of Guardians (LBG) meeting. With thanks.

Ricardo Banwarie
Assistant Chief Probation & Social Services Officer

INSTRUCTIONS

To claim Public Medical Assistance, Claimants must read page 1 & 2 of this form, and provide a true response to all questions herein.

Medical Data

10 - Name of applicant ----------
Name of the person with medical condition

11 - ID of applicant ----------
ID of the person with medical condition

12 - Date of Birth ----------
Date of birth of person with medical conditions

13 - Sex
Sex of person with medical condition ☐ Male ☐ Female

20 - Name of Medical Practitioner: ----------

Medical Condition Type	Likely to Recover	Impact on Capacities

30 - Disability Level ☐ Temporary ☐ Permanent

40 - Medical Practitioner Signature ----------

50 - General Description of disabilities ----------

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60 - Effect on daily living and employment ----------

70 - Name of the legal representative ----------
(In case of medical incapacity)

PUBLIC ASSISTANCE MEDICAL INQUIRY/ REVIEW

Additional Information

The following information must eb provided only if the person with medical condition is an adult

10 - Union Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Common Law ☐ Visiting Relation

20 - Employment Status ☐ Employed ☐ Un-employed

Employment Period	Employer's Name	Monthly Income in GYD

30 - Are you in receipt of another assistance? ☐ Yes ☐ No

40 - Monthly Amount in GYD of the benefit: ----------

Declaration

I declare that al the responses on this form are true and correct to the best of my knowledge and belief.

…… ……

Signature/mark Date

PENALTY FOR FALSE STATEMENT

Any Person who knowingly makes any false statement, or false representation for the purpose of obtaining or continuing a public assistance service either for one self or for any other person, shall be liable on summary conviction to a fine or imprisonment.

DECISION

Decision Made

10 - Decision Made: ----------

(Approved / Rejected / Closed / Deferred)

11 - First Payment Date

Must be a first of a month ----------

12 - Last Date of payment ----------

Must be a first of a month

13 - Number of Booklets: ----------

Number of coupons

14 - Reason: ----------

Reason why the case was rejected or deferred

20 - Signature/mark:

PLC Chairman ---------- Date: ……..

LBG Chairman ---------- Date: ……..

Chief Probation & Social Services Officer ---------- Date: ……..

Director of Social Services ---------- Date: ……