SENATE PUBLIC ASSISTANCE OFFICE (SPAO)

Medical Assistance Form

DATE: _____ **EMAIL ADDRESS:** _____

PATIENT'S DETAILS:

FIRST NAME	MIDDLE NAME	LAST NAME

DATE OF BIRTH	AGE	CONTACT NUMBER

SEX: **MALE** ☐ **FEMALE** ☐

COMPLETE ADDRESS

_____

MONTHLY HOUSEHOLD INCOME (Kabuuang kita ng pasyente at mga kasama sa bahay)

☐ Less than 10,000
☐ 10,000 - 20,000
☐ 21,000 - 40,000
☐ 41,000 - 100,000
☐ 101,000 and above

MEDICAL INFO:

DOH HOSPITAL

_____

DIAGNOSIS

_____

ASSISTANCE NEEDED

☐ Hospital Bill
☐ Laboratory
☐ Diagnostic Procedure
☐ Medicines
☐ Dialysis / Hemodialysis
☐ Chemotherapy / Chemo Drugs
☐ Operation/Surgery
☐ Others : indicate below _____

REQUIREMENTS: Ilakip ang mga sumusunod kasama ng SPAO Form na ito

1. Personal letter to the Senator
2. Clinical Abstract / Medical Certificate
3. Hospital Bill / Treatment Protocol / Laboratory or Diagnostic Procedure Request / Precription
4. Brgy Certificate of Indigency
5. Social Case Study Report from Local DSWD or Hospital Social Worker
6. Patient's ID or Authorized Representative

* Pinapahintulutan ang paggamit ng mga impormasyon na nakasaad sa form na ito at kalakip na dokumento para sa pagproseso ng aking aplikasyon.