



**MEDICAL ACCESS 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** _____ 6. **EDAD** _____ 7. **KASARIAN:** Lalake Babae
(Birth Date) mm/dd/yyyy (Age) (Sex)

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:** In-Patient Out-Patient
(Nature of Requested Assistance)

PAGPAPA-OSPITAL (Confinement) **GAMOT** (SPECIALTY MEDICINES): SPECIFY: _____

DIALYSIS: _____ EPOETIN INJECTION
_____ HEMODIALYSIS TREATMENT **LABORATORY/DIAGNOSTIC PROCEDURE**
TUKUYIN (PLS. SPECIFY) _____

CANCER TREATMENT: _____
_____ CHEMODRUGS **MEDICAL DEVICE (PACEMAKER, STENT, SEPTAL OCCLUDER**
_____ RADIATION THERAPY VALVES, VP-SHUNT, ETC.)

ORTHOPEDIC (BONE) IMPLANT

TREATMENT/PROCEDURES FOR CATASTROPHIC ILLNESSES

_____ **Kidney Transplant**
_____ **Liver Transplant; and**
_____ **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.)

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:

NOT FOR SALE