NATIONAL DEVELOPMENT FUND FOR PERSONS WITH DISABILITIES (NDFPWD)
ASSISTIVE DEVICES AND TECHNOLOGIES
APPLICATION FORM-PO/AP/1

NOTE: SUBMISSION OF APPLICATION DOES NOT GUARANTEE SUPPORT

SECTION A: PERSONAL DETAILS

1. NAME: ……
2. SEX: ❑ MALE ❑ FEMALE ❑ INTERSEX
3. DATE OF BIRTH: (DD/MM/YY) ……
4. NATIONAL ID NUMBER: (ATTACH A COPY) ……
5. DISABILITY IDENTIFICATION NUMBER: (ATTACH A COPY) ……
6. STATE DISABILITY: ……
7. CAUSE OF DISABILITY: ❑ CONGENITAL ❑ ACQUIRED (STATE YEAR ACQUIRED) ……
8. PERMANENT AREA OF RESIDENCE:

   COUNTY: ……SUB-COUNTY…… LOCATION……

   SUB LOCATION……TELEPHONE: ……

9. IF APPLICANT IS UNDER 18 YEARS,

   NAME OF PARENT/GUARDIAN: ……

   NATIONAL ID. NO: …… RELATIONSHIP TO APPLICANT……

10. STATE IF YOU HAVE ANY SPECIAL COMMUNICATION NEEDS:
    ❑ TEXT ONLY ❑ SIGN LANGUAGE ❑ LARGE PRINT ❑ BRAILLE

    OTHER (SPECIFY) ……

SECTION B: PROFESSIONAL RECOMMENDATION ON THE APPROPRIATE ASSISTIVE DEVICE (S)

1. DESCRIBE THE APPLICANT'S NATURE OF DISABILITY……

   ……

2. STATE THE ASSISTIVE DEVICE/TECHNOLOGY RECOMMENDED (ATTACH SPECIFICATIONS)

   ……

3. NAME OF RECOMMENDINGOFFICER……..

   DESIGNATION……

   NAME OF INSTITUTION… ……..

   SIGNATURE AND STAMP: ……DATE: ……

SECTION C: ASSISTIVE DEVICE(S)/TECHNOLOGY REQUESTED

1. DO YOU HAVE ANY ASSISTIVE DEVICES CURRENTLY IN USE: ❑ YES ❑ NO

   IF YES:

   a) STATE TYPE OF DEVICE……
   b) SOURCE OF DEVICE ❑ NDFPWD ❑ OTHER (SPECIFY)……..
   c) DATE RECEIVED……

2. ASSISTIVE DEVICE(S) REQUESTED (AS RECOMMENDED BY A PROFESSIONAL)

   ❑ WHEELCHAIR ❑ TRICYCLE ❑ CALIPERS ❑ SURGICALBOOTS
   ❑ CRUTCHES ❑ PROSTHESIS ❑ WALKING SUPPORT ❑ HEARING AID
   ❑ SPEECH AID ❑ BRAILLE DEVICE ❑ WHITE CANE

   ❑ COMPUTER SOFTWARE (EG. JAWS) OTHER (SPECIFY) ……

SECTION D: DECLARATION

- ❑ I HAVE ATTACHED THE FOLLOWING DOCUMENTS:

  A) COPY OF NATIONAL IDENTIFICATION CARD (OF APPLICANT OR OF GUARDIAN IF APPLICANT IS UNDER 18YRS)
  B) COPY OF DISABILITY IDENTIFICATION CARD
  C) ORIGINAL PROFESSIONAL ASSESSMENT REPORT FOR THE APPROPRIATE ASSISTIVE DEVICE WHERE APPLICABLE

I …… CERTIFY THAT THE INFORMATION PROVIDED ON THIS APPLICATION IS TRUE AND CORRECT.

SIGNATURE: ……DATE: ……..

SECTION E: FOR OFFICIAL USE – NCPWD COUNTY DISABILITY SERVICES OFFICER

❑ I DO / DO NOT [TICK AS APPROPRIATE] RECOMMEND THE FOLLOWING INDIVIDUAL TO NDFPWD FOR SUPPORT.

REASON FOR RECOMMENDATION/ REJECTION:

……

……

❑ I CONFIRM THAT ALL THE RELEVANT DOCUMENTS ARE ATTACHED AND CORRECT

NAME OF OFFICER: …… COUNTY: ……

SIGNATURE AND STAMP: ……DATE SUBMITTED ON MIS: ……

SECTION F: FOR OFFICIAL USE – NDFPWD – HEADQUARTERS

RECEIVED BY:

NAME OF OFFICER: ……

DESIGNATION: ……

SIGNATURE AND STAMP: …… DATE APPROVED ON MIS: ……

REFERENCE NO: ……