****

**Annex 1**

**PMAC Form**

**COOPERATIVE DEVELOPMENT AUTHORITY**

**PROGRAM ON MEDICAL ASSISTANCE FOR COOPERATIVES**

**APPLICATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| BUONG PANGALAN NG APLIKANTE (FULL NAME) |  |  |  |
| APELYIDO (SURNAME) | PANGALAN (NAME) | GITNANG PANGALAN (MIDDLE NAME) |
| PERMANENTENG TIRAHAN (PERMANENT ADDRESS) |  |  |  |  |
| NO. , STREET | BARANGAY | MUNICIPALITY | PROVINCE |
| KATAYUAN SIBIL(CIVIL STATUS) | * Walang asawa (single)
* Kasal (married)
 | * Balo (widower)
* Hiwalay (separated)
 |
| KASARIAN(GENDER) | * Babae
* Lalaki
 | Nationality: \_\_\_\_\_\_\_\_\_\_\_\_Relihiyon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| NATAPOS NA ANTAS NG PAG-AARAL(EDUCATIONAL ATTAINMENT) | * Post-graduate
* Vocational
* College
 | * Highshcool
* Elementary
* Walang Natapos
 |
| HANAPBUHAY(EMPLOYMENT) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Buwanang Kita: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| MIYEMBRO NG PAMILYA NA KASAMA SA BAHAY:(HOUSEHOLD MEMBERS)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Pangalan | Edad | Katayuang Sibil | Relasyon sa Pasyente | Natapos na Pag-aaral | Hanap-buhay | Buwanang Kita |
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| Diagnosis:  |
| Hinihinging Tulong: | * In-patient
* Out-patient
 |
| * Pagpapa-ospital
* Dialysis
* Chemotheraphy
* Radiation therapy
* Gamot
* Kagamitan sa Operasyon
* Implant
 | * Laboratory/diagnostic Proceure (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Medical Device (pacemaker, stent, etc)
* Assistive Device (hearing aid, wheelchair, etc)
* Transplant
* Others
 |
| Mga kaukulang papeles na isinubmit sa CDA Regional Office:* Duly accomplished PMAC Form completed by the applicant member;
* Any of the following government-issued ID of the patient such as Passport, Driver’s License, GSIS UMID, SSS ID, PRC ID, NSO Authenticated Birth Certificate, Digitized Voter’s ID, PhilHealth ID, Senior Citizen’s ID, Government Issued Office ID, DSWD-4Ps ID, Student ID, Coop ID and Barangay Certificate; and
* Original/Certified True Copy of the Clinical Abstract (for inpatient & chemotherapy)/ Medical Certificate for outpatient duly signed by the attending physician/ oncologist with printed full name, signature and license number in the absence of the coop member-applicant, authorization Letter from the patient authorizing his/her immediate family member, to transact with and receive the assistance from the CDA and
* Letter request from the cooperative-member addressed to CDA
* Current running bill from the hospital
* Certificate of Confinement
* Letter-endorsement duly signed by the Chairman or the General Manager with certification that the applicant is a legitimate member/s
 |

Pinatutunayan ko na ang lahat ng inilahad ko dito ay pawang 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lagda o Thumbmark ng Aplikante sa ltaas ng Pangalan

Signature or Thumbmark Above Applicant's Printed Name

ID na lpinakita (Valid ID presented) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kung walang ID, Sertipikasyon/Pruweba ng Pagkakakilanlan (In lieu of ID, Certification/Proof of Identity)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kung kinatawan, Relasyon sa Pasyente (Relationship to Patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Numerong Telepono (Contact No.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VALIDATED BY:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDA REPRESENTATIVE