



Healthy Teeth Collaboration Application Form

Notes:

1. Please use a black or blue ball pen to fill in this application form in block letters. All information must be completed in English unless otherwise stated.
2. Please put a “✓” in the appropriate box(es) “☐”.
3. Do not use correction tools. If there are inaccuracies, the applicant / representative of Part II should mark the amendments and initials next to them.
4. To apply for the services under Healthy Teeth Collaboration (“the Programme”), person with eligible disability (“the applicant”) may apply on their own or agent (parent / grandparent / brother / sister / spouse), legal guardian or representative of rehabilitation service unit may fill in Part II of this application form and submit application on behalf of the applicant.
5. The agent / legal guardian / representative of rehabilitation service unit must present all the document proof listed in Part III of this application form when making an application to the non-governmental organisation dental clinic (“the dental clinic”) on behalf of the applicant. If the agent / legal guardian cannot accompany the applicant for the first appointment, please pass the completed application form and all the original documentary proof listed in Part III (A copy of the Hong Kong Identity Card can be provided for verification unless the legal guardian or agent cannot accompany the applicant in person) to the person accompanying the applicant for the first appointment, and submit them to the non-governmental organisation dental clinic. Non-governmental organisation dental clinic may refuse applications with incomplete information.

Part I Personal Particulars of Applicant (Applicant must be aged 18 or above with intellectual disability and/or Autism Spectrum Disorder)

Name in Chinese: _____ Name in English: _____

Gender: ☐ Male ☐ Female

Hong Kong Identity Card No.: _____ (____)

Date of Birth: _____ (yyyy) _____ (mm) _____ (dd) Contact Telephone No.: _____

Correspondence Address: _____

Person applying for the Programme: ☐ Applicant
☐ Agent (Please fill in Part II (A))
☐ Legal Guardian appointed by the Guardianship Board (Please fill in Part II (B))
☐ Representative of Rehabilitation Service Unit (Please fill in Part II (C))

Disability Category: ☐ Intellectual Disability
☐ Autism Spectrum Disorder
☐ Intellectual Disability and Autism Spectrum Disorder

Part II(A) Personal Particulars of Agent

(The agent is not authorised to give consent to dental care services for the applicant under the Programme.)

☐ Parent ☐ Grandparent ☐ Brother/ Sister ☐ Spouse

Name of Agent in Chinese: _____ Name of Agent in English: _____

Gender: ☐ Male ☐ Female

Hong Kong Identity Card No.: _____ (____)

Date of Birth: _____ (yyyy) _____ (mm) _____ (dd) (The agent must be aged 18 or above)

Correspondence Address: _____

Contact Telephone No.: _____ (Home or Office) _____ (Mobile Phone) _____

Email Address (if applicable): _____

Part II(B) Personal Particulars of Legal Guardian

(Note: The Guardianship Board appoints legal guardian of the person with intellectual disability under the Mental Health Ordinance (Cap. 136). The guardianship order gives the legal guardian the power to give consent to dental care services for the applicant under the Programme.)

(The legal guardian is authorised to give consent to dental care services for the applicant under the Programme.)

Name of Legal Guardian in Chinese: _____ Name of Legal Guardian in English: _____

Hong Kong Identity Card No.: _____ (____)

Correspondence Address: _____

Contact Telephone No.: _____ (Home or Office) _____ (Mobile Phone) _____

Email Address (if applicable): _____

Part II(C) Information of Representative of Rehabilitation Service Unit

(The representative of rehabilitation service unit is not authorised to give consent to dental care services for the applicant under the Programme.)

Name of Rehabilitation Service Unit which the applicant is currently receiving services:

Representative of Rehabilitation Service Unit: _____ Contact Telephone No.: _____

Address of Rehabilitation Service Unit: _____

Email Address (if applicable): _____

Chop of Rehabilitation Service Unit: _____

Part III Declaration and Undertaking by Applicant / Agent / Legal Guardian / Rehabilitation Service Unit

1. I have read and fully understand the Appendix I "Guidance Notes" of this application form and agree to its contents.
2. I have read the Appendix II "Personal Information Collection Statement" of this application form and fully understand its contents.
3. I declare that all information provided in this application form and other information submitted/to be submitted under the Programme is true and correct. I understand that if I knowingly or wilfully make any false statement or withhold any information or otherwise mislead the Department of Health, for the purpose of obtaining subsidised dental services under the Programme, it will render me liable to prosecution. I understand that the deliberate provision of false information or omission of information in order to obtain financial assistance under the Programme by deception is a criminal offence. I may be liable to prosecution and on conviction to imprisonment for a maximum of 14 years under the Theft Ordinance (Cap. 210).

Signature of Applicant/
representative of Part II: _____

Name (in block letters): _____ Date: _____

Please present the original copy of the following documents to the non-governmental organisation dental clinic when submitting application form:

Applicable to all applicants

- ☐ Completed Part I to Part III of the application form;
- ☐ Hong Kong Identity Card of the applicant;
- ☐ One of the following documents certifying the disability category as “intellectual disability”, “mental handicap” or “Autism Spectrum Disorder”.
 - ☐ Valid Registration Card for People with Disabilities issued by the Labour and Welfare Bureau; or
 - ☐ Medical certificate or “Certificate of Disability Type for Healthy Teeth Collaboration (HTC01E)”(as attached to the application form) issued by a doctor registered in Hong Kong ; or
 - ☐ “Certificate of Disability Type for Healthy Teeth Collaboration (HTC01E)”(as attached to the application form) issued by the person-in-charge of a rehabilitation service unit under the designated types of rehabilitation services #

#Designated types of rehabilitation services include Care and Attention Home for Severely Disabled Persons, Hostel for Severely Mentally Handicapped Persons, Hostel for Moderately Mentally Handicapped Persons, Supported Hostel, Integrated Vocational Training Centre (Residential Service), Day Activity Centre, Sheltered Workshop, Integrated Vocational Rehabilitation Services Centre, Integrated Vocational Training Centre (Day Service), District Support Centre for Persons with Disabilities and Day Care Service for Persons with Severe Disabilities as listed in Social Welfare Department’s site at <https://www.swd.gov.hk/tc/pubsvc/rehab/>.

Applicable to legal guardian or agent

- ☐ Hong Kong Identity Card of the legal guardian or agent (A copy of the Hong Kong Identity Card can be provided for verification if the legal guardian or agent cannot accompany the applicant in person); and
- ☐ Guardianship order issued by the Guardianship Board (applicable to a person who applies for the Programme by a legal guardian appointed by the Guardianship Board); or
- ☐ Proof of relationship, e.g. applicant’s birth certificate, marriage certificate of the agent and the applicant, statutory declaration or self-declaration stating the relationship between the agent and the applicant (applicable to a person who applies for the Programme by an agent)

Part IV Eligibility of Applicant (For Dental Clinic Use)**Registration No. (Please call DH for the no.):**

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Check the application form☐ Part I to Part III of the application form have been completed.Check the original Hong Kong Identity Card of the applicant☐ The information on applicant's Hong Kong Identity Card tallies with Part I of the application form.Check the original of one of the following documents certifying the disability category as “intellectual disability”, “mental handicap” or “autism spectrum disorder”:☐ Valid Registration Card for People with Disabilities issued by the Labour and Welfare Bureau☐ Permanent☐ Valid until: _____(yyyy) _____(mm)☐ Medical certificate or “Certificate of Disability Type for Healthy Teeth Collaboration (HTC01E)” issued by a doctor registered in Hong Kong☐ “Certificate of Disability Type for Healthy Teeth Collaboration (HTC01E)” issued by the person-in-charge of a rehabilitation service unit under the designated types of rehabilitation services #.

Designated types of rehabilitation services include Care and Attention Home for Severely Disabled Persons, Hostel for Severely Mentally Handicapped Persons, Hostel for Moderately Mentally Handicapped Persons, Supported Hostel, Integrated Vocational Training Centre (Residential Service), Day Activity Centre, Sheltered Workshop, Integrated Vocational Rehabilitation Services Centre, Integrated Vocational Training Centre (Day Service), District Support Centre for Persons with Disabilities and Day Care Service for Persons with Severe Disabilities as listed in Social Welfare Department's site at <https://www.swd.gov.hk/tc/pubsvc/rehab/>

Check the original (if he / she attends the appointment with the applicant) or copy of the documentary proof of legal guardian / agent☐ Information in Part II of the application form should tally with the Hong Kong Identity Card of the legal guardian / agent.**Part II (A): Agent**

One of the following relationship proofs:

- ☐ Birth certificate of the applicant; or
- ☐ Marriage certificate of the applicant and representative of Part II; or
- ☐ Statutory declaration stating the relationship between the applicant and representative of Part II (if the above relationship proof cannot be provided)
- ☐ Self-declaration; or

☐ Others: _____**Part II (B): Legal Guardian**

Check the guardianship order issued by the Guardianship Board

☐ The information on the guardianship order tallies with the information of the applicant and legal guardian in the form**Result of Eligibility:**

- ☐ The applicant of Part I is **eligible** to apply for the services under the Programme.
- ☐ The applicant of Part I is **not eligible** to apply for the services under the Programme.

Name of Dental Clinic Staff_____
Signature of Dental Clinic Staff

Date: _____(yyyy) _____(mm) _____(dd)

Chop of Dental Clinic