Certificate of Disability Type for Healthy Teeth Collaboration (HTC)

Name of the HTC applicant: _____ Sex: M☐ F☐

HK Identity Card No.: _____

Please fill in either Section A or Section B.

(Section A) ***To be completed by the doctor***	***(Section B)*** ***To be completed by the person-in-charge of the rehabilitation service unit under the designated types of rehabilitation services[#]*** ***(Both questions must be answered)***
This is to certify the above named HTC applicant is a person with ☐ intellectual disability ☐ autism spectrum disorder ☐ intellectual disability and autism spectrum disorder	1/ This is to certify the above named HTC applicant is a person with ☐ intellectual disability ☐ autism spectrum disorder ☐ intellectual disability and autism spectrum disorder 2/ Service users under the following type of rehabilitation services. ☐ 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 ☐ Day Care Service for Persons with Severe Disabilities

[#] 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/

Signature: _____

Name of Doctor / Person-in-charge of the Rehabilitation Service Unit: _____

Name of Clinic / Rehabilitation Service Unit: _____

Chop of Clinic / Rehabilitation Service Unit: _____

Date : _____