Republika ng Pilipinas
LUNGSOD NG MAKATI

OFFICE OF THE MAYOR
MAKATI ACTION CENTER

Date: ____________________

AUTHORIZATION

This is to authorize ______________________________ of Barangay ____________________,
MAC Coordinator to submit my Yellow Card to the Office of the Makati Health Program (MHP) and facilitate its processing and renewals.

____
PRINTED NAME AND SIGNATURE

Address: ______________________________
____
____

For MAC use only:

REQUIREMENTS OF NEW APPLICANT:

( ) Latest Comelec Certification
( ) PhilHealth Member Data Record (MDR)
( ) Barangay Clearance Certificate
( ) Marriage Contract (If Married
( ) Birth Certificate of Qualified Dependent
( ) 1x1 ID Picture of Applicant
( ) Family Picture
( ) Realty Property Tax Title and Tax Receipt
( ) PWD ID
( ) White Card and Blu Card Photo Copy (Senior Citizen)
( ) Prenatal Check up Photo Copy (If Pregnant)
( ) National Government Agency (Certificate of Employment)

REQUIREMENTS FOR RENEWALS OF YELLOW CARD:

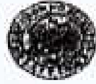
( ) Old MHP Lam Yellow Card
( ) Latest Comelec Certificate
( ) PhilHealth Member Data Record (MDR)
( ) Barangay Clearance (If Change of Address)

Checked by: ______________________________
MAC Coordinator – Printed Name and Signature

Noted by : ______________________________
MAC- Team Leader – Printed Name and Signature

HIV SECTION 8-3-20

"Ang Makati ay para sa kapwa ko taga Makati."



CITY GOVERNMENT OF MAKATI

MAKATI HEALTH PLUS PROGRAM

APPLICATION FORM

MAKATI HEALTH PLUS INFORMATION SHEET: | **DATE APPLIED:** ____________

MHP TYPE: ☐ W/DEPENDENTS ☐ SOLO | ☐ SENIOR CITIZEN ☐ W/DEPENDENTS ☐ SOLO | ☐ MCG ☐ W/DEPENDENTS ☐ SOLO | ☐ NGA | ☐ PWD ☐ SOLO ☐ W/DEPENDENTS

LAST NAME	FIRST NAME	MIDDLE NAME

ADDRESS: ____________ **BARANGAY:** ____________

SEX: ______ **CIVIL STATUS:** ______ **DATE OF BIRTH:** ______ **AGE:** ______ **BLOOD TYPE:** ______

TEL. NO./CELL NO.: ______ **HOUSE:** ☐ Owned ☐ Rented ☐ Living w/ Relative ☐ Transient

EMPLOYMENT STATUS: ☐ Permanent ☐ Contractual/Casual ☐ Self-Employed ☐ Unemployed ☐ Retiree

SWORN STATEMENT:

That I am not confined nor one of my dependents at Ospital ng Makati (OSMAK) and that I have no outstanding balance and/or promissory note in the said hospital.

______________________ Applicant's Signature Over Printed Name

______________________ MHP Interviewer's Signature Over Printed Name

DEPENDENTS:

NAME	RELATIONSHIP	SEX	DATE OF BIRTH/AGE	OCCUPATION	MONTHLY INCOME

LIST OF REQUIREMENTS:

- ( ) COMELEC Certification
- ( ) PhilHealth Member Data Record (MDR)
- ( ) Barangay Clearance Certificate
- ( ) Birth Certificate of Qualified Dependents
- ( ) Marriage Contract (If Married)
- ( ) 1x1 ID Picture of Applicant
- ( ) Family Picture
- ( ) Real Property Title and Tax Receipt
- ( ) PWD ID
- ( ) White Card and Blu Card Photo Copy ([illegible])
- ( ) Prenatal Check-up Photo Copy (If Pregnant)
- ( ) National Government Agency (Certificate of Employment)

Approve for Home Visitation:

____

JOEMARIE Y. MALBOG
DEPUTY, MAKATI HEALTH PLUS

DATA PRIVACY CONSENT

In Compliance with the Data Privacy Act (DPA) of 2012, and its Implementing Rules and Regulations (IRR) effective since September 8, 2016, I allow the Makati Health Plus Program (MHPP) to collect and use my personal information in relation to my purpose of / application for Yellow Card and other legal purpose/s it may be intended for.

As such, I also agree and authorize them to:

1. Retain and store my information for a certain period of time as prescribed by law from the date of the accomplishment of the purpose stated above. I agree that my information will be deleted / destroyed after this period.
2. Share my information to other office / department within the City Government of Makati and necessary third parties for any legitimate purpose. I am assured that security systems are employed to protect my information.
3. I alone can view, change and recover the personal information I shared unless I authorize a representative on my behalf armed with a Special Power of Attorney duly notarized for this purpose. This applied also to any request for a certified true copy bearing any of my personal information.
4. Inform me of future services or projects offered by the City Government of Makati using the personal information I shared.
5. I hold free and harmless and indemnify the City Government of Makati, any of its office/departments, officers, employees and agents from any complaint, suit, or damages which any party may file or claim in relation to the Data Privacy Act.

Signed this ______ day of ______ 20 ___ at ____________ City.

______________________ (Signature Over Printed Name)

______________________ (Address)

______________________ (Contact Number)

HOME VISITATION: (For MAC Interviewer's only)

☐ Makati Residents ☐ Not Bonafide Resident

☐ Unemployed

☐ Employed at ______________ w/monthly of ______ or daily income

DATE OF NOTICE TO CLAIM:

MM	DD	YYYY

I declare, under the penalties of perjury that information given above is true and correct and has been made in good faith, verified by me and to the best of my knowledge and belief.

______________________ **APPLICANT'S OR CARDHOLDER'S** Signature Over Printed Name

______________________ **MAC INTERVIEWER** Signature Over Printed Name

______________________ **HOME VISITATION-IN-CHARGE** Signature Over Printed Name

Approved By:

____

BENITA C. TANYAG
ACTING CITY GOVERNMENT ASST. DEPT. HEAD II

Health Project of:

MAYOR MAR-LEN ABIGAIL S. BINAY AND CITY COUNCIL

CITY GOVERNMENT OF MAKATI
MAKATI HEALTH PLUS PROGRAM

ACKNOWLEDGEMENT AND CLAIM STUB

Date: ______________________

This is to acknowledge that Mr./Ms./Mrs. ____ is a bona fide resident of ____ based on the Home Visitation conducted by the Makati Action Center (MAC).

This also serves as claim stub for his/her MAKATI HEALTH PLUS CARD which he/she will claim at **Ground floor Makati Health Plus Office, New Makati City hall Building** on ______________________.

Certified By:

____
MAC COORDINATOR
Signature over Printed Name

MHP COPY

DATA PRIVACY CONSENT

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Signed this ____________ **day of** ________ **20**___ **at** ________________ **City.**

____
(Signature Over Printed Name)

____
(Address)

____
(Contact Number)

This portion is to be filled out by MAKATI HEALTH PLUS personnel upon the release of card

Released By:	Received By:
______________________	______________________
MHP Staff	CARD HOLDER/AUTHORIZED REPRESENTATIVE
Date: ______________	Date: ______________

CITY GOVERNMENT OF MAKATI
MAKATI HEALTH PLUS PROGRAM

ACKNOWLEDGEMENT AND CLAIM STUB

Date: ______________________

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Certified By:

____
MAC COORDINATOR
Signature over Printed Name

APPLICANT'S COPY

This portion is to be filled out by MAKATI HEALTH PLUS personnel upon the release of card

Released By:	Received By:
______________________	______________________
MHP Staff	CARD HOLDER/AUTHORIZED REPRESENTATIVE
Date: ______________	Date: ______________