PWSD CT PROGRAMME – PAYMENT OF ARREARS

BENEFICIARY / CAREGIVER UPDATE TEMPLATE

Programme No.: _____

1. CAREGIVER BASIC INFORMATION (Caregiver details as per the CCTPMIS)

Name (In Full) _____

I.D. No. _____ Sex _____

Date of Birth _____

Telephone No.: _____ (**Must be registered in the Caregiver's name and ID for purposes of payment using Mpesa**)

Mobile Service Provider _____ (Safaricom, Airtel, Telkom)

Relation to the Beneficiary _____ (Parent, Guardian, Family member, etc)

Details / Reason for Change: _____

_____

2. BENEFICIARY BASIC INFORMATION

Name (In Full) _____

I.D. No. (Where applicable _____ Sex _____

Date of Birth _____

Nature of Disability _____ Disability Reg. No. _____

3. GEOGRAPHICAL DATA/PHYSICAL ADDRESS

County _____

Sub-County _____

Location _____

Sub-Location _____

Nearest Landmark/Village_____

4. ALTERNATIVE CONTACT DETAILS (for purposes of reaching caregiver in the event he/she is un-reachable)

Name: _____

Telephone Number _____

Relationship to the Beneficiary _____

5. DECLARATION (Caregiver)

I, _____ (Caregiver) hereby declare that the information given above is true to the best of my knowledge, and confirm this by signing / appending my signature.

6. RECOMMENDED BY (AREA CHIEF/ASSISTANT CHIEF)

Name _____ Signature & Stamp: _____

Date: _____

7. OFFICIAL USE (Form Acted on By Regional Coordinator and County Disability Services Officer):

COUNTY DISABILITY SERVICES OFFICER	REGIONAL COORDINATOR DISABILITY SERVICES
Name:	**Name**:
Signature:	**Signature**:
Date:	**Date**: