

**SUPPLEMENTAL / BID BULLETIN NO. 02**

**TITLE** : Supplemental Bid Bulletin for the **PROCUREMENT OF FORMS  
FOR THE IMPLEMENTATION OF AICS**

**ITB NO.** : **DSWD12-CIS-2025-05-009**

**DATE** : 21 April 2025

This Supplemental/Bid Bulletin is issued to all prospective bidders announcing the following amendments and clarifications:

**Addendum/Amendment Details**

SECTION		
Section VI Schedule of Requirements and Section VII Technical Specifications		
<b>As part of the bid submission</b> , all participating bidders are required to attach a sample printed copy of the CIS forms		
<b>The sample printed forms are essential to ensure that the bidders are able to meet the requirements for the procurement of the CIS forms</b>		

This Bid Bulletin shall form part of the bidding documents.

Please be guided accordingly.

  
**JACKIYA A. LAO**  
Chairperson, DSWD FOXII BAC

Please accomplish the portion below and email at [procurement.fo12@dswd.gov.ph](mailto:procurement.fo12@dswd.gov.ph).

Received from DSWD, **Supplemental/Bid Bulletin No. 02** for the **DSWD12-CIS-2025-05-009 PROCUREMENT OF FORMS FOR THE IMPLEMENTATION OF AICS**

**RECEIVED BY** : \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(SIGNATURE OVER PRINTED NAME)

**DESIGNATION** : \_\_\_\_\_

**COMPANY** : \_\_\_\_\_

# STEP FORM

Control No.:  Date:     
Month Day Year

Time Arrived:  ☐ AM ☐ PM

Pangalan   
(First Name)

Gitnang Pangalan   
(Middle Name)

Apelyido   
(Last Name)

MODE OF PAYMENT: ☐ Guarantee Letter (GL) ☐ Cash Out Right (COR)

TIME NAME OF DSWD PERSONNEL  
Signature Over Printed Name

Time Start

Time Start

Time Start

Time Start

Time Start

**STEP: 1**  
SCREENING OF  
DOCUMENTS/ CRIMS:

**STEP: 2**  
A. INTERVIEW (Social  
worker):

B. CLIENT SATISFACTION  
SURVEY:

**STEP: 3**  
APPROVAL:

**STEP: 4**  
RELEASE OF ASSISTANCE:

Remarks

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SURVEY:

**STEP: 3**  
APPROVAL:

**STEP: 4**  
RELEASE OF ASSISTANCE:

Remarks

# INFORMATION SHEET

 PCN: 

 Date     
 MM DD YYYY

## IMPORMASYON NG KINATAWAN/KLIYENTE (Authorized Representative's/Client's Identifying Information)

Apelyido (Last Name)		Unang Pangalan (First Name)		Gitnang Pangalan (Middle Name)		Ext. (Sr., Jr., I, II)	
Numero ng Bahay/Kalye (Street Address)		Barangay (Ex. Batasan Hills)		Lungsod/Bayan (City/Municipality)		Lalawigan/Distrito (Province/District)	
Numero ng Mobile (Mobile No.)		Petsa ng Kapanganakan (Birthdate) MM-DD-YYYY		Kasarian (Sex)		Katayuang Sibil (Civil Status)	
Hanapbuhay (Occupation)		Buwanang Kita (Monthly Income)					
Relasyon sa Benepisyaryo (Relationship to the Beneficiary)							

## IMPORMASYON NG BENEPISYARYO (Beneficiary's Identifying Information)

☐ KATULAD NG NASA ITAAS

Apelyido (Last Name)		Unang Pangalan (First Name)		Gitnang Pangalan (Middle Name)		Ext. (Sr., Jr., I, II)	
Numero ng Bahay/Kalye (Street Address)		Barangay (Ex. Batasan)		Lungsod/Bayan (City/Municipality)		Lalawigan/Distrito (Province/District)	
Numero ng Mobile (Mobile No.)		Petsa ng Kapanganakan (Birthdate) MM-DD-YYYY		Kasarian (Sex)		Katayuang Sibil (Civil Status)	
Hanapbuhay (Occupation)		Buwanang Kita (Monthly Income)					

 Ikaw ba ay nakakuha na ng tulong mula sa DSWD?  
 (Have you received any assistance from the DSWD?)

- ☐ Hindi
- ☐ Oo

 Natanggap na tulong sa DSWD (Assistance received from DSWD)  
 Gamitin ang likurang bahagi ng papel kung kinakailangan

1	
2	
3	
4	
5	

Petsa ng tulong (Date of assistance received)


## KOMPOSISYON NG PAMILYA (Family Composition)

Paalala: Gamitin ang likurang bahagi ng papel kung kinakailangan.

	Buong Pangalan (Full Name)	Relasyon sa Benepisyaryo (Relationship to the Beneficiary)	Edad (Age)	Hanapbuhay (Occupation)	Buwanang Kita (Monthly Income)
1					
2					
3					
4					
5					

## DEKLARASYON NG PAHINTULOT (Consent Form)









Ako ay nagdedeklara sa ilalim ng parusa ng pagsisinungaling (perjury), na ang lahat ng impormasyon sa aplikasyon na ito ay totoo at tama batay sa aking personal na kaalaman at mga autentikong rekord na isinumite sa Department of Social Welfare and Development (DSWD). Anumang mali o mapanlinlang na impormasyon na ibinigay, o paggawa ng pekeng/pinagwaglit na mga dokumento ay magiging sanhi ng nararapat na hakbang na legal laban sa akin at awtomatikong magpawalang-bisa sa anumang tulong na ibibigay kaugnay ng aplikasyon na ito.

Ako ay sumasang-ayon na ang lahat ng personal na datos (ayon sa depinisyon sa ilalim ng Republic Act 10173 o Data Privacy Law ng 2012 at mga patnubay nito) at impormasyon o mga rekord ng mga transaksyon sa account sa DSWD ay maaaring iproseso, i-profile, o ibahagi sa mga humihiling na partido o para sa layunin ng anumang hukuman, proseso ng batas, pagsusuri, inquiry, audit, o imbestigasyon ng anumang awtoridad.

Lagda sa ibabaw ng Buong Pangalan ng Kinatawan/Kliyente  
 (Signature over Printed Name of the Authorized Representative/Client)

Thumbmark

NATANGGAP NA TULONG MULA SA DSWD (Assistance Received from DSWD)					
Natanggap na tulong (Date of assistance received)			Petsa ng tulong (Date of assistance received)		
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
KOMPOSISYON NG PAMILYA (Family Composition)					
	Buong Pangalan (Full Name)	Relasyon sa Benepisyaryo (Relationship to the Beneficiary)	Edad (Age)	Hanapbuhay (Occupation)	Buwanang Kita (Monthly Income)
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
PAGE 2 of 2					
DSWD Field Office XII, Purok Bumanaag, Brgy. Zone III, Koronadal City, Philippines (9506) Website: <a href="http://www.fo12.dswd.gov.ph">http://www.fo12.dswd.gov.ph</a> Tel Nos.: (083)228-2086 Telefax: (083)228-2086					

<div><div><div>Department of Social Welfare and Development</div></div><div><div>BACANG PILIPINAS</div></div></div>		<div>CLIENT SATISFACTION MEASUREMENT FORM</div> <div>DSWD-QMS-GF-005   REV 05   05 OCT 2023</div> <div>DSWD FO XII – Protective Division/CRISIS INTERVENTION SECTION</div>					
<div>CERTIFICATE OF INFORMED CONSENT</div> <div>I voluntarily give my consent for the use of my personal information. I confirm that I have read the provided information, or it has been read to me. I have had the opportunity to ask questions about it, and any inquiries I made were answered to my satisfaction. I understand that any information collected will be utilized solely to enhance the basic social services provided by DSWD.</div> <div>(Client's Signature or Thumb Mark)</div>							
Date of Transaction (dd/mm/yyyy)		Name of Client (First,MI,Last)			Age		
<div>Sex</div> <div><input type="checkbox"/> Male</div> <div><input type="checkbox"/> Female</div> <div><input type="checkbox"/> Prefer not to say</div>		<div>Client Type</div> <div><input type="checkbox"/> Citizen (General Public)</div> <div><input type="checkbox"/> Business (Private Organization)</div> <div><input type="checkbox"/> Government (Employee or another agency)</div> <div><input type="checkbox"/> Others: _____</div>			<div>Sector</div> <div><input type="checkbox"/> Person with Disability</div> <div><input type="checkbox"/> Senior Citizen</div> <div><input type="checkbox"/> Indigenous People</div> <div><input type="checkbox"/> Solo Parent</div> <div><input type="checkbox"/> Children and Youth</div> <div><input type="checkbox"/> Women</div> <div><input type="checkbox"/> Others: _____</div>		
Contact Number/Email Address		Address (Barangay,Municipality,Province)			Name of Attending Action Officer		
<div>INSTRUCTION: <b>Check mark (✓)</b> your answer to the Citizen's Charter (CC) questions. The <b>Citizen's Charter</b> is an official document that reflects the services of a government agency/office including its requirements, fees, and processing times among others.</div>							
<div>CC1: Which of the following best describes your awareness of a CC?</div> <div><ul style="list-style-type: none"><li>1. I know what a CC is and saw this office's CC.</li><li>2. I know what a CC is but I did NOT see this office's CC.</li><li>3. I learned of the CC only when I saw this office's CC.</li><li>4. I do not know what CC is and I did not see one in this office. (Answer N/A in CC2 and CC3)</li></ul></div>		<div>CC2: If aware of CC (answered 1-3 in CC1), would you say that the CC of this office was...?</div> <div><ul style="list-style-type: none"><li>1. Easy to see</li><li>2. Somewhat easy to see</li><li>3. Difficult to see</li><li>4. Not visible at all</li><li>5. N/A</li></ul></div>			<div>CC3: If aware of CC (answered 1-3 in CC1), how much did the CC help you in your transaction?</div> <div><ul style="list-style-type: none"><li>1. Yes, I was able to use the CC</li><li>2. No, I was not able to use the CC</li><li>3. Did not help</li><li>4. N/A</li></ul></div>		
<div>INSTRUCTION:For Service Quality Dimension (SQD) 0-8, please put a <b>check mark (✓)</b> on the column that best corresponds to your answer.</div>		Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Not Applicable
		(5)	(4)	(3)	(2)	(1)	(N/A)
							
SQD0. I am satisfied with the service that I availed.							
SQD1. I spent a reasonable amount of time for my transaction.							
SQD2. The office followed the transaction's requirements and steps based on the information provided.							
SQD3. The steps (including payment) I needed to do for my transaction were easy and simple.							
SQD4. I easily found information about my transaction from the office or its website.							
SQD5. I paid a reasonable amount of fees for my transaction. (If services was free, mark the 'N/A' column)							
SQD6. I feel the office was fair to everyone, or "walang palakasan", during my transaction.							
SQD7. I was treated courteously by the staff, and (if asked for help) the staff was helpful.							
SQD8. I got what I needed from the government office, or (if denied) denial of request was sufficiently explained to me.							
<div>Feedback (Optional): Please provide your commendations, suggestions, or complaints so that we can further improve the delivery of our services to you.</div>							

THANK YOU!



## GENERAL INTAKE SHEET

- ☐ AICS  
☐ AKAP  
☐ Others: \_\_\_\_\_

☐ New  
☐ Returning

- ☐ Onsite  
☐ Malasakit Center  
☐ Offsite

☐ Walk-in  
☐ Referral

Date :     
MM DD YYYY

### CLIENT'S NAME

\_\_\_\_\_  
Last Name First Name Middle Name Ext. (Sr,Jr,I,II)

### BENEFICIARY'S NAME ☐ SAME AS ABOVE

\_\_\_\_\_  
Last Name First Name Middle Name Ext. (Sr,Jr,I,II)

PURPOSE OF ASSISTANCE : \_\_\_\_\_

DIAGNOSIS/CAUSE OF DEATH (if funeral) : \_\_\_\_\_

MODE OF ASSISTANCE : ☐ Outright Cash ☐ Guarantee Letter ☐ Material Assistance ☐ Psychosocial Support ☐ Referral Service

AMOUNT NEEDED : **PhP** \_\_\_\_\_

### I. INCOME AND FINANCIAL RESOURCES

#### Occupation/s of family member

Employed

(indicate number of members working) \_\_\_\_\_

Seasonal Employee

(indicate number of members working) \_\_\_\_\_

#### Combined family income

- ☐ Insurance coverage  
☐ Savings

### II. BUDGET AND EXPENSES

- ☐ Monthly expenses of the family \_\_\_\_\_  
(Utility bills, Maintenance and Medication, Mortgage/Rent, Debt, and Others)

- ☐ Availability of emergency fund

### III. SEVERITY OF THE CRISIS

#### How long does the patient suffer from the disease?

- ☐ Recently diagnosed (3mos & below)  
☐ 3 months to a year  
☐ chronic or lifelong  
☐ not applicable

#### In the past three (3) months, did the family experience at least one crisis?

- ☐ YES ☐ NO

#### If yes, which among the following crises did the family experience in the past three (3) months (check all that apply):

- ☐ Hospitalization  
☐ Death of a family member  
☐ Catastrophic Event (fire, earthquake, flooding, etc.)  
☐ Disablement  
☐ Loss of Livelihood  
☐ Others, specify \_\_\_\_\_

### IV. AVAILABILITY OF SUPPORT SYSTEMS

- ☐ Family  
☐ Relatives  
☐ Friend/s  
☐ Employer  
☐ Church/Community Organization

### V. EXTERNAL RESOURCES TAPPED BY THE FAMILY

- ☐ Philhealth  
☐ Health Card  
☐ Guarantee Letter from other agencies  
☐ MSS Discount  
☐ Senior Citizen Discount  
☐ PWD Discount \_\_\_\_\_  
☐ Others, specify \_\_\_\_\_  
☐ Not applicable

### VI. SELF HELP AND CLIENT EFFORTS

- ☐ Successfully sought employment opportunities or explored additional income sources  
☐ Successfully reached out to relevant organization

### VII. VULNERABILITY AND RISK FACTORS

- ☐ There are elderly/ Child in need/ PWD/ Pregnant in the household  
☐ A member is physically or mentally incapacitated to work  
☐ Inability to secure stable employment

## VIII. CLIENT SECTOR

### Target Sector:

- ☐ FHONA    ☐ SC  
☐ WEDC    ☐ YNSP  
☐ PWD    ☐ PLHIV  
☐ CNSP

### Specify Sub-Category:

- ☐ Solo Parent    ☐ Recovering Person Who Used Drugs  
☐ Indigenous People    ☐ Minimum Wage Earner below minimum wage  
☐ Street Dwellers    ☐ Earner (specify approximate monthly income) Php  
☐ KIA/WIA  
☐ 4PS Beneficiary    ☐ No Regular Income  
☐ Stateless Person    ☐ Others: \_\_\_\_\_  
☐ Asylum Seekers  
☐ Refugees

### Type of Disability:

- ☐ Speech Impairment    ☐ Mental Disability  
☐ Learning Disability    ☐ Visual Disability  
☐ Psychosocial Disability    ☐ Intellectual Disability  
☐ Deaf/Hard-of-Hearing    ☐ Physical Disability  
☐ Cancer    ☐ Rare Disease

### Source of Income:

- ☐ Salaries/Wages from Employment  
☐ Entrepreneurial income/profits  
☐ Cash assistance from domestic source  
☐ Cash assistance from abroad  
☐ Transfers from the government (e.g. 4Ps)  
☐ Pension  
☐ Other income

### Amount:

Php \_\_\_\_\_  
 Php \_\_\_\_\_  
 Php \_\_\_\_\_  
 Php \_\_\_\_\_  
 Php \_\_\_\_\_  
 Php \_\_\_\_\_  
 Php \_\_\_\_\_  
**Total income in the past 6 months**    **Php** \_\_\_\_\_

## IX. PROBLEM PRESENTED

## X. SOCIAL WORKER'S ASSESSMENT

### ☐ FINANCIAL ASSISTANCE

- ☐ Medical    ☐ Food Assistance  
☐ Funeral    ☐ Cash Relief Assistance  
☐ Transportation  
☐ Educational

### ☐ MATERIAL ASSISTANCE

- ☐ Family Food Packs  
☐ Other Food Items  
☐ Hygiene & Sleeping Kits  
☐ Assistive Devices & Technologies  
☐ Rice

### ☐ PSYCHOSOCIAL SUPPORT

- ☐ Psychosocial First Aid (PFA)  
☐ Social Work Counseling

### ☐ REFERRAL:

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

### Purpose of Assistance

### Amount

### Fund Source

1			
2			
3			

### Interviewed by:

### Reviewed & Approved by:

\_\_\_\_\_  
 Social Worker  
 (Signature over Printed Name)  
 License no.: \_\_\_\_\_

\_\_\_\_\_  
 Approving Authority  
 (Signature over Printed Name)



# CERTIFICATE OF ELIGIBILITY

QN:  PCN:

Date:     
MM DD YYYY

☐ AICS ☐ New ☐ Onsite ☐ Walk-in  
☐ AKAP ☐ Returning ☐ Malasakit Center ☐ Referral  
☐ Others: \_\_\_\_\_ ☐ Offsite

Birthdate:     
MM DD YYYY

This is to certify that \_\_\_\_\_,  
First Name Middle Name Last Name Extension Name  
and presently residing at \_\_\_\_\_  
Complete Address

has been found eligible for assistance after the assessment and validation conducted, for him/herself or in representation of his/her

Relationship of the Beneficiary to the Client

First Name Middle Name Last Name Extension Name

## Records of the case such as the following are confidentially filed at the Crisis Intervention Program (CIP)

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> General Intake Sheet | <input type="checkbox"/> Medical Certificate / Abstract | <input type="checkbox"/> Laboratory Request     | <input type="checkbox"/> Contract of Employment     |
| <input type="checkbox"/> Justification        | <input type="checkbox"/> Prescriptions                  | <input type="checkbox"/> Promissory Note /      | <input type="checkbox"/> Certificate of Employment  |
| <input type="checkbox"/> Valid I.D. Presented | <input type="checkbox"/> Statement of Account           | <input type="checkbox"/> Certificate of Balance | <input type="checkbox"/> Certificate of Attestation |
| _____   | <input type="checkbox"/> Treatment Protocol             | <input type="checkbox"/> Funeral Contract       | <input type="checkbox"/> Income Tax Return          |
|   | <input type="checkbox"/> Quotation/Charge Slip          | <input type="checkbox"/> Transfer Permit        | <input type="checkbox"/> Others                     |
|   | <input type="checkbox"/> Discharge Summary              | <input type="checkbox"/> Death Certificate      | _____   |
|   | <input type="checkbox"/> Social Case Study Report       | <input type="checkbox"/> Death Summary          |   |
|   | <input type="checkbox"/> Case Summary Report            | <input type="checkbox"/> Referral Letter        |   |

### If Outright Cash

The client is hereby recommended to receive  
\_\_\_\_\_ assistance for  
*Type of assistance: food, medical, cash relief, transportation, others*  
\_\_\_\_\_ in the amount of  
*Purpose of assistance*  
\_\_\_\_\_  
*Amount in words*  
PhP \_\_\_\_\_  
*Amount in figures*

### If Guarantee Letter

GL No.   
The client is hereby recommended to receive  
\_\_\_\_\_ assistance for  
*Type of assistance: medical, burial, others*  
\_\_\_\_\_ in the amount of  
*Purpose of assistance*  
\_\_\_\_\_  
*Amount in words* PhP \_\_\_\_\_  
*Amount in figures*  
payable to \_\_\_\_\_  
*Name of Service provider*  
\_\_\_\_\_  
*Address of Service provider*

Prepared and certified by:

Approved by:

\_\_\_\_\_  
Social Worker  
(Signature over Printed Name)  
License Number: \_\_\_\_\_

\_\_\_\_\_  
Approving Authority  
(Signature over Printed Name)

## ACKNOWLEDGMENT RECEIPT

Date:     
MM DD YYYY

I acknowledge receipt of assistance in the amount of \_\_\_\_\_  
*Amount in words* PhP \_\_\_\_\_  
*Amount in figures*

Received by:

\_\_\_\_\_  
Client  
(Signature over Printed Name)

GL No. \_\_\_\_\_

Date. \_\_\_\_\_

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

Dear \_\_\_\_\_

This has reference to the request for the \_\_\_\_\_ of  
herein client, \_\_\_\_\_, from \_\_\_\_\_,  
for his/her \_\_\_\_\_, \_\_\_\_\_.

The Department of Social Welfare and Development has assessed and validated the  
said request for assistance through the Crisis Intervention Unit/Section. Thus, the  
Department is issuing this letter to guarantee the payment of the bill in the amount of  
\_\_\_\_\_ (Php \_\_\_\_\_).

To facilitate the payment, please submit to the Crisis Intervention Unit/Section through  
\_\_\_\_\_ the following documents for the preparation of the Disbursement  
Voucher within one week after the service has been completed.

Ø Guarantee Letter (GL) from the DSWD with your company's "received" stamp or  
signature over the printed name of the authorized representative.

Ø Statement of Accounts (SOA) or Billing Statement or Sales Invoice with  
corresponding operative technique or charge slip addressed to DSWD

Please be informed that said payment will be directly deposited to your company's  
bank account. Should there be any query, you may call us at \_\_\_\_\_.

For your consideration.

Thank you.

Very truly yours,

\_\_\_\_\_  
Approving Authority  
Position: \_\_\_\_\_  
Office: \_\_\_\_\_

**Valid until** \_\_\_\_\_

*\*validity period includes the time of receipt of the guarantee letter by the service provider*