

Application Form for Accreditation

Status of Application: <input type="checkbox"/> New Application <input type="checkbox"/> Renewal <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd </div> <div> <input type="checkbox"/> 4th <input type="checkbox"/> 5th <input type="checkbox"/> Others, pls. specify _____ </div> </div>	DSWD Previously Issued Accreditation: <div style="margin-top: 10px;">❖ Accreditation No: _____</div> <div style="margin-top: 5px;">❖ Date of Issuance: _____</div> <div style="margin-top: 5px;">❖ Date of Expiration: _____</div>
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I. Identifying Information:

Name of Applicant SWDA (as stated on the SEC Registration)		
Other Name (e.g., acronym, short name, previous name, etc.)		
Business Address:	No. and Street/ Subdivision:	
	Barangay	
	City/Municipality	
	Province	
	Zip Code	
Head of Applicant SWDA	Name	
	Position/Designation	
Contact details	Landline No.	
	Fax No.	
	Mobile No.	
	Social Media Account	
	E-mail address	
Principal Registration (Juridical Personality)	Website	
	Agency (SEC)	
	Registration No.	
Mayor's Permit	Date Registered	
	Place Issued	
	Issued No.	
	Date Issued:	
Validity Period:		

II. Specific Objectives of the SWDA (pls. state and attached separate page, if necessary):

1. _____
2. _____
3. _____
4. _____
5. _____

II. Profile of Program to be Accredited

Type of Programs and Services per Service Delivery Mode	Area of Coverage/Location (pls. specify)			Target Beneficiaries (please indicate number of beneficiaries being served per specific category e.g. under children Sector - 5 neglected, 3 abused etc)								
	Region	City/Province	Municipality	Children	Youth	Women	Older Person	PWD	Family	Community	Disasters Victims	Others (Specify)
a. Community-based												
b. Center-based (pls. indicate specific name of each facility with corresponding bed capacity and programs and services to be or being provided to the clientele)												

III. Staff Complement (current year)

Name of Facility/ Satellite Office/ Areas of Operation	Staff Complement	No. and Composition of Staff Complement per Facility/Satellite Office/Areas of Operation			
		Full time/ Regular Staff	Part time Staff	Volunteer Staff	Total
	Management ➤ Executive Director/Agency Head ➤ Others, pls. specify:				
	Program Staff ➤ Registered Social Worker ➤ Community Development Worker ➤ House parents/ caregivers ➤ Others, please specify:				
	Support Staff (please specify)				

IV. Budget:
1. Annual Budget (Latest): _____

2. Source of Funds: Please specify the organization's specific sources of funds whether government or private organizations/individuals, local and/or international/foreign including other resource generation activities with the corresponding amount of funds covered annually in peso value. If foreign, there is a need to specify the country location.

a. Local Source
Peso Value

b. **Foreign Source**

Peso Value

**I hereby certify that the information on this application form and
all supporting application documents are true and correct.**

(Signature Over Printed Name of the Agency Head or Authorized Representative)

(Position/Designation of the Agency Head or Authorized Representative)

(Date)

Note: If will be eligible for issuance of Certificate of Accreditation, kindly check the appropriate box on how the organization would like to receive the Certificate:

☐ Through courier

☐ pick-up at DSWD Office

(Field Office or Standards Bureau, as applicable)

Authorization:

On behalf of the applicant SWDA, I hereby:

- (a) Authorize Mr./Ms./Mrs. _____, (Full name of authorized representative)
our _____, as our official representative to transact with DSWD
covering _____
(designation in the organization)
all the requirements and processes set in our application for Accreditation of SWD
programs and services
- (b) Allow the DSWD to inspect the premises of the office(s) and residential facility(ies)
and/or satellite/branch offices of the our organization, as well as the site of any past or
present project or program of the organization, and
- (c) Authorize any concerned person of the organization to disclose to the DSWD any fact
material to the validation of any information provided by our organization in this
application or in any of the documents submitted in support thereof.
- (d) Attest that all information in this application together with all the supporting documentary
requirements are true and correct.

AFFIANT – Authorized Representative	Signature	
	Name	
	Position/Designation	
Date executed		
Place executed		

SUBSCRIBED AND SWORN to before me, on the above date and place, affiant exhibiting the following identification document:

Government ID Type and No.	
Place and date of issue	
Valid until	