

Free Delivery Service Provided by Supermarkets for Persons with Disabilities

Notes to Applicants

1. Background and Purpose

As stated in the “Government Response to the Consumer Council’s Report on the Supermarket Industry” published by the then Trade and Industry Bureau in 1995, local major supermarket operators had initially accepted the Hong Kong Council of Social Service’s proposal of providing free delivery service (the service) for persons with disabilities. In following up this proposal, the then Health and Welfare Bureau and Social Welfare Department obtained consent from Park’N Shop Limited (Park’N Shop) and Wellcome Company Limited (Wellcome) to provide the service.

2. Eligibility

The following four groups of persons with disabilities and their families/carers are eligible for the service:

- (1) persons with severe physical disability (including those suffering from cerebral palsy/using wheelchairs or walking aids);
- (2) persons with severe low vision or totally blind;
- (3) persons with severe intellectual disability (IQ 40 or below); and
- (4) persons with autism.

3. Application Forms

Application Forms are obtainable at:

- 3.1 Rehabilitation service units and special schools that provide services for the four groups of persons mentioned in paragraph 2 above;
- 3.2 Social Security Field Units and Integrated Family Service Centres of the Social Welfare Department; or
- 3.3 Labour and Welfare Bureau website (www.lwb.gov.hk).

4. Application Procedures

- 4.1 Applicants must be persons with disabilities or their family members/carers. They are required to complete Parts A and C of the Application Form. Applicants who are family members or carers of persons with disabilities are required to complete Part B as well. If an order is placed by the family members or carers of persons with disabilities, the delivery address should be the same as the residential address indicated in Part A of the Application Form.
- 4.2 Persons with disabilities who are receiving rehabilitation services such as those provided by special schools, day activity centres and residential homes should ask the officers-in-charge of the respective agencies to complete the “Letter of Certification” at Annex I and submit with the application photocopies of the personal identification listed in Part A of the Application Form for the purpose of certifying the information given in the Application Form.
- 4.3 Persons with disabilities who are not receiving any rehabilitation services should:
- 4.3.1 complete the “Letter of Authorisation” at Annex II to authorise the Rehabilitation Division of the Labour and Welfare Bureau to verify the information provided in the Application Form, and attach to the Application Form photocopies of their personal identification and relevant supporting documents as listed in Part A of the Application Form and the “Letter of Authorisation” respectively; or
- 4.3.2 attach to the Application Form photocopies of the personal identification listed in Part A of the Application Form, and a valid medical certificate¹ to prove that the person indicated in Part A belongs to one of the four groups of persons mentioned in paragraph 2 above.

¹ There is no standard format for medical certificates. The sample in Annex III may be used as reference.

- 4.4 The Application Form together with the documents listed in 4.2 or 4.3 above should be mailed to the following address:

Rehabilitation Division
Labour and Welfare Bureau
11/F, West Wing, Central Government Offices
2 Tim Mei Avenue, Tamar, Hong Kong

5. Rights and Responsibilities

- 5.1 The Rehabilitation Division of the Labour and Welfare Bureau will examine and verify the applications and refer eligible applications to the respective supermarket operators for further action. The Labour and Welfare Bureau reserves the right to reject any application in case the applicant provides any false or incorrect information, or in case the eligibility of the applicant is in doubt.
- 5.2 Successful applicants must strictly observe the terms and conditions laid down by the respective supermarket operators for the use of the service.
- 5.3 Free delivery service will be provided by the supermarkets, but the operators reserve the right to amend the terms and conditions relating to the service.

6. Enquiries

Please call the Rehabilitation Division of the Labour and Welfare Bureau at 2810 3859.

Rehabilitation Division
Labour and Welfare Bureau

Free Delivery Service Provided by Supermarkets for Persons with Disabilities

Application Form

Part A: Personal Particulars of the Person with Disabilities (This part must be completed.)

Name : (in Chinese) _____ (in English) _____

Residential Address :

(in Chinese) _____

(in English) _____

Telephone No. : _____

Sex : _____ Date of Birth : _____

Personal

Identification : ☐ Hong Kong Identity Card No. : _____

☐ Exemption Certificate No. : _____

☐ Birth Certificate No. : _____
(applicable to persons under the age of 11)

Type of

Disability : ☐ Severe physical disability (including persons suffering
from cerebral palsy/using wheelchairs or walking aids)

☐ Severe low vision or totally blind

☐ Severe intellectual disability (IQ 40 or below)

☐ Autism

Please tick as appropriate

Part B : Personal Particulars of Family Member/Carer (please complete this part if applicable)

Name : (in Chinese) _____ (in English) _____

Hong Kong Identity Card No. : _____ Telephone No. : _____

Relationship with the person with disabilities indicated in Part A:

☐

family member

☐

carer

Part C : Declaration

I* hereby declare that the information given in this Application Form is true and correct, and consent to the information being registered with the Central Registry for Rehabilitation under the Labour and Welfare Bureau (“the Registry”) and to the information being forwarded from the Registry to Park’N Shop and Wellcome so that I can receive free delivery service provided by # ☐ Park’N Shop/ ☐ Wellcome respectively (you may tick more than one box). I understand that the information, other than being used for the above purpose, will be kept confidential. I am also fully aware of the objectives and intention (details shown below) of the Registry in collecting the information.

Signature of Applicant : _____ Date : _____

Name: (in Chinese) _____ (in English) _____

Please tick as appropriate.

* Referring to the same person as indicated in Part A or B of this Application Form.

Function of the Central Registry for Rehabilitation

The Central Registry for Rehabilitation collects and compiles data on persons with disabilities in Hong Kong with a view to providing statistics on disability to Government departments and non-governmental organisations for planning of rehabilitation services and research purposes. Personal information will be kept confidential and will not be disclosed to other persons or organisations except in the form of summary statistics. It is only upon the express agreement of the person with disabilities concerned that his/her own data, including type(s) of disability, may be released to a third party or organisations authorised by him/her.

Free Delivery Service Provided by Supermarkets for People with Disabilities

Letter of Certification

(To be completed by rehabilitation service units for persons with disabilities who *are receiving* rehabilitation services or their family members/carers.)

I hereby certify that the information about _____ (name of the person with disabilities) given in the Application Form is true and correct.

Signature of

Officer-in-charge: _____ Date : _____

Name : _____ Post Title : _____

Telephone No.: _____

Name and chop of the rehabilitation service unit:

Free Delivery Service Provided by Supermarkets for Persons with Disabilities

Letter of Authorisation

(To be completed by persons with disabilities who are *not receiving* rehabilitation services or their family members/carers.)

I* hereby attach a photocopy of the personal identification document indicated in Part A of the Application Form and provide information on one of the following items. I also authorise the Rehabilitation Division of the Labour and Welfare Bureau to verify the information given in Part A of the form:

☐ Information on disability allowance

The person indicated in Part A of the Application Form is a recipient of disability allowance, whose reference number is _____. Attached is a photocopy of a **notification of successful application for disability allowance / notification of revision of assistance issued by the Social Welfare Department.

☐ Information on Comprehensive Social Security Assistance (CSSA)

The person indicated in Part A of the Application Form is a recipient of CSSA payment, whose reference number is _____. Attached is a photocopy of a **notification of successful application for CSSA payment / notification of revision of assistance issued by the Social Welfare Department.

☐ Loss of the notification of successful application for disability allowance / CSSA payment

The **disability allowance / CSSA payment reference number of the person indicated in Part A of the Application Form is _____. However, since the **notification of successful application for disability allowance / CSSA payment issued by the Social Welfare Department has been lost, the Welfare Branch (Rehabilitation Division) of the Labour and Welfare Bureau is requested to verify direct with the Social Welfare Department the information about the person with disabilities indicated in the Application Form.

Signature: _____ Date: _____

Name: (in Chinese) _____ (in English) _____

* Referring to the same person as indicated in Part A or B of the Application Form.

Please tick as appropriate.

** Delete as appropriate.

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Sample of Medical Certificate

This is to certify that _____ (name of the person with disabilities; Hong Kong Identity Card / Birth Certificate No.: _____) is suffering from one of the following types of disabilities:

- # ☐ Severe physical disability (including persons suffering from cerebral palsy / using wheelchairs or walking aids)
- ☐ Severe low vision or totally blind
- ☐ Severe intellectual disability (IQ 40 or below)
- ☐ Autism

Signature: _____

Name of doctor: _____

Name of Clinic / Hospital: _____

Tel. No.: _____

Date: _____

Clinic / Hospital Chop

Please tick as appropriate.