



DEPARTMENT OF SOCIAL WELFARE AND DEVELOPMENT  
Field Office VII  
Corner M.J. Cuenco and Gen. Maxilom Ave., Cebu City

**REQUEST FOR QUOTATION  
NP- SMALL VALUE PROCUREMENT**

RFQ No. : DSWD7-2025-0754

Date : May 23, 2025

Company Name : \_\_\_\_\_  
Company Address : \_\_\_\_\_  
Contact Person : \_\_\_\_\_  
Contact No. : \_\_\_\_\_  
PhilGEPS Registration No.: \_\_\_\_\_

**Sir/Madam:**

Please quote your government price/s including delivery charges, VAT or other applicable taxes, and other incidental expenses for the goods listed in Annex A. Failure to indicate information could be the basis for non-compliance. Also, kindly furnish us with descriptive brochures, catalogues, literatures and/or samples, if applicable.

If you are the exclusive manufacturer, distributor or agent in the Philippines for the goods listed in **Annex A**, please attach in your quotation a duly notarized certification to this effect.

Interested supplier/s are required to submit true copies of their **valid Mayor's Permit, Philgeps Registration Number, and Latest Income Tax Return** upon submission of quotation/s. An **omnibus Sworn Statement** is required prior to award.


Please accomplish and submit this **form** together with **Annex A** and **Bank Information** to the BAC Secretariat, DSWD Field Office VII, Cebu City or send it through facsimile numbers (032) 887-9720; 233-0261; 231-2172 local 17140 or 17110 or e-mail to [bac.fo7@dswd.gov.ph](mailto:bac.fo7@dswd.gov.ph) on or before **May 28, 2025 at 5:00PM.**

Very truly yours,

  
**ENGR. EMMANUEL M. EDLES**  
AO V/Head, Procurement Management Section

**Terms and Conditions:**

- Award shall be made on per: ☐ item basis ☒ total quoted price ☐ lot basis
- Quotation validity shall be not less than **60 calendar days.**
- Good/s or Services shall be delivered **please refer to Annex A**
- Place of Delivery: **DSWD FO VII, Corner M.J. Cuenco Avenue and Gen. Maxilom Ext., Carreta, Cebu City**
- Terms of Payment: **within 30 days from the receipt of billing statement.**
- Liquidated Damages/Penalty: **One-tenth of one percent for everyday of delay shall be imposed.**
- In case of discrepancy between total price per item and unit price for the item as extended or multiplied by the quantity of that item, the latter shall prevail.
- Warranty period, if applicable: \_\_\_\_\_

  
**CHARL ALBERT J. TORREFIEL**  
Canvasser

I am interested to quote and agree to the terms and conditions.

\_\_\_\_\_  
(Signature over Printed Name of Supplier / Service  
Provider / Authorized Representative)



DEPARTMENT OF SOCIAL WELFARE AND DEVELOPMENT  
Field Office VII, Cebu City

Company Name \_\_\_\_\_  
Company Address \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Contact No. \_\_\_\_\_  
PhilGEPS Registration No.: \_\_\_\_\_  
Tin Number: \_\_\_\_\_

RFQ No.: DSWD7-2025-0754

Date: May 23, 2025

Item No.	Quantity	Unit of Measure	Articles / Descriptions	Statement of Compliance (State "Comply" or "Not Comply")	Bidder's Specifications	Unit Cost	Total Cost
			<b>Supply and Delivery of Various Forms</b>				
1	1,300	pad	<b>Certificate of Eligibility Form #1</b>  Description:  Paper Stocks: Carbonless Paper Size: A4, 21cm(w)x 29.7cm(h) (8.27 x 11.69 ") No. of Copies: 2 copies (White & Yellow) Prints: 1/0, Black Finish: Padded/100 sets per pad				
2	600	ream	<b>General Intake Sheet - Form #2</b>  Description:  Paper Stocks: White Bond Econo subs.20 (50gsm) Size: A4, 21cm(w)x 29.7cm(h) (8.27 x 11.69 ") Prints: 1/1, Black (back to back) Finish: 1 ream = 500 sheets				
3	600	ream	<b>Information Sheet - Form # 3</b>  Description:  Paper Stocks: White Bond Econo subs.20 (50gsm) Size: A4, 21cm(w)x 29.7cm(h) (8.27 x 11.69 ") Prints: 1/1, Black (back to back) Finish: 1 ream = 500 sheets				
<b>Total:</b>							
<b>Approved Budget for the Contract: Php 983,400.00</b>				Note: "Bidder's Specifications" column may be filled up with service provider or may copy "Articles/Description" stated if applicable.			
End User: <b>CIS</b>							
<b>PURPOSE :</b> For AICS and AKAP use							

Note: Procurement procedure in accordance with DSWD-Memorandum Circular No. 2, Series of 2007.

  
**CHARAL ALBERT J. TORREFIEL**  
 Canvasser

Signature of Supplier / Authorized Representative Over  
 Printed Name

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☐ Central Office  
☒ Field Office VII

## CERTIFICATE OF ELIGIBILITY

QN:  PCN:

☐ AICS

☐ AKAP

☐ Others: \_\_\_\_\_

☐ New

☐ Returning

☐ Onsite

☐ Malasakit Center

☐ Offsite

☐ Walk-in

☐ Referral

Date:     
MM DD YYYY

Birthdate:     
MM DD YYYY

This is to certify that

First Name Middle Name Last Name Extension Name

Sex

Age

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)

- ☐ General Intake Sheet  
☐ Justification  
☐ Valid I.D. Presented

- ☐ Medical Certificate / Abstract  
☐ Prescriptions  
☐ Statement of Account  
☐ Treatment Protocol  
☐ Quotation/Charge Slip  
☐ Discharge Summary  
☐ Social Case Study Report  
☐ Case Summary Report

- ☐ Laboratory Request  
☐ Promissory Note /  
Certificate of Balance  
☐ Funeral Contract  
☐ Transfer Permit  
☐ Death Certificate  
☐ Death Summary  
☐ Referral Letter

- ☐ Contract of Employment  
☐ Certificate of Employment  
☐ Certificate of Attestation  
☐ Income Tax Return  
☐ Others

#### 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:

Social Worker

(Signature over Printed Name)

License Number: \_\_\_\_\_

Approved by:

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)



## 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

**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 \_\_\_\_\_

**VI. SELF-HELP AND CLIENT EFFORTS**
☐ Successfully sought employment opportunities or explored additional income sources

☐ Successfully reached out to relevant organizations or agencies for financial assistance or support

**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

Form # 3



- ☐ Central Office  
☒ Field Office VII

## 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/Distrto (Province/District, Rehiyon (Region)	
Numero ng Mobile (Mobile No.)	Petsa ng Kapanganakan (Birthdate) MM-DD-YYYY	Edad (Age)	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/Distrto (Province/District, Rehiyon (Region)	
Numero ng Mobile (Mobile No.)	Petsa ng Kapanganakan (Birthdate) MM-DD-YYYY	Edad (Age)	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?)		Natanggap na tulong sa DSWD (Assistance received from DSWD) Gamitin ang likurang bahagi ng papel kung kinakailangan			Petsa ng tulong (Date of assistance received)		
<input type="checkbox"/> Hindi <input type="checkbox"/> Oo		1 _____ 2 _____ 3 _____ 4 _____ 5 _____			_____ _____ _____ _____ _____		

### 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.*

