Republic of the Philippines
Department of Education
Region V
SCHOOLS DIVISION OF SORSOGON

DIVISION MEMORANDUM
No. 87 ,s.2026

TO: **Asst. Schools Division Superintendent**
SGOD and CID Chiefs
Functional Area Heads
Education Program Supervisors
Division Coordinators
Public Schools District Supervisors
OIC-Public Schools District Supervisors
Elementary and Secondary School Heads
Teaching and Non-Teaching Personnel

FROM: **JOSE L. DONCILLO, CESO V**
Schools Division Superintendent

SUBJECT: **SUBMISSION OF REPORTORIAL REQUIREMENTS FOR 2025 MEDICAL ALLOWANCE**

DATE: **FEBRUARY 19, 2026**

1. Pursuant to DBM Circular No. 2024-6 dated December 12, 2024 and DepEd Order No. 6, 2025 dated June 9, 2025, all DepEd SDO Sorsogon Personnel who availed of 2025 Medical Allowance through Individual Cash Disbursement are hereby enjoined to submit documents to support the use of Medical Expenses or Purchase of Individual HMO.

2. Personnel who availed Cash Disbursement for the purpose of availment of new or renewal of Individual HMO may submit any of the following proofs:

   a. copy of the HMO agreement;
   b. valid identification card (ID) issued by the HMO provider reflecting the name of the employee; or
   c. official receipt for the payment of the membership fee for the HMO product acquired.

Balogo Sports Complex, Balogo, Sorsogon City, Sorsogon 4700
Landline: (056) 211-6461
Email: sorsogon@deped.gov.ph
Website: depedsorsogon.com.ph

3. Personnel who availed Cash Disbursement for the purpose of payment of medical expenses shall submit a signed Individual Cash Claim Form (refer to attached Annex B), copy of original receipts and supported by any of the following certification:

   a. GIDA Certification (signed by the Schools Division Superintendent)
   b. Certification of area with no HMO
   c. Letter or email from HMO denying application

4. The abovementioned 2025 Medical Allowance Reportorial Requirement/s shall be consolidated by school and shall be submitted at the Records Section not later than February 26, 2026.

5. Failure to comply shall result in the withholding of personnel's medical allowance for FY 2026 until such obligations have been satisfactorily settled.

6. Immediate and wide dissemination of this memorandum is hereby enjoined.

7. For information, guidance and immediate compliance.

Annex B
Individual Cash Claim Form

Data Privacy Notice: The Department of Education recognizes its responsibility under the Republic Act No. 10173, otherwise known as the *Data Privacy Act of 2012*, with respect to the data they collect, record, organize, update, use, consolidate or destruct from their personnel. The personal data obtained from this form is entered and stored within the organization's authorized information and communications system and will only be accessed by authorized personnel. The organization has instituted appropriate technical and physical security measures to ensure the protection of personal data.

Furthermore, the information collected and stored in the portal shall only be used for the purposes of this activity. DepEd shall not disclose any personal information without consent and shall retain this information over a period of ten years for the effective implementation and management of its activities.

Section 1: Employee Information
Full Name: _____
Employee ID Number: _____
Position/Designation: _____
Office: _____
Service Duration: (From – To): _____

Sex: ____ Date of Birth (dd/mm/yyyy): _____
Mobile Number: _____
DepEd Email Address: _____

For teaching personnel
Region: _____
Division: _____
School: _____
Employment Status: ☐ Permanent ☐ Contractual ☐ Casual ☐ Substitute

Section 2: Pre-requisite Requirements.

Supported with applicable documents, check any of the following condition below that applies.

☐ GIDA Certification
☐ Certification of area with no HMO
☐ Letter or email from HMO denying the application

Section 3: Details of Medical Expenses Incurred

Name of Medical Provider/Facility	**Address**	**Date(s) of Medical Consultation/Service**

(Please add rows as necessary)		

Description of Expense	**Amount (in PHP)**	**Receipt No./Reference**
Consultation Fee		
Laboratory/Diagnostic Tests		
Medication		
Hospitalization		
Others (please specify)		
Total Amount		

Please attach original receipts

Section 3: Certification

I, the undersigned, hereby certify that the information provided in this claim form is true and correct to the best of my knowledge, and the medical expenses listed above were incurred for legitimate medical purposes. I understand that submission of false claims shall be subject to disciplinary action and other legal consequences as determined necessary by the Department of Education.

Employee's Signature: _____ **Date:** _____