



Republic of the Philippines
Department of Education
Region II – Cagayan Valley
SCHOOLS DIVISION OF NUEVA VIZCAYA

March 18, 2026

DIVISION MEMORANDUM

No. 136 s. 2026

ENROLLMENT AND ORIENTATION ON THE PHILHEALTH YAKAP (YAMAN NG KALUSUGAN PROGRAM) UNDER THE SCHOOL HEALTH AND NUTRITION UNIT CLINIC (SHNUC)

To: Assistant Schools Division Superintendent
Chief-School Governance Operations Division
Chief-Curriculum Implementation Division
All Others Concerned

1. In support of the Department of Education's commitment to promote the **health, safety, and well-being of teaching and non-teaching personnel**, the Schools Division Office of Nueva Vizcaya, through the **Schools Governance and Operation Division - School Health and Nutrition Unit Clinic (SHNUC)**, is facilitating the enrollment of personnel in the **PhilHealth YAKAP (Yaman ng Kalusugan Program)**. The **PhilHealth YAKAP Program** is part of the implementation of the **Primary Care Benefit Package** under the **Universal Health Care (UHC) Act (Republic Act No. 11223)**, which aims to ensure that all Filipinos have access to **comprehensive, preventive, promotive, curative, and rehabilitative health services** without financial hardship. Through this program, PhilHealth members and their dependents may access **free primary healthcare services through accredited primary care providers**, including consultation, diagnostic tests, and essential medicines. The **School Health and Nutrition Unit Clinic (SHNUC)** serves as a **Primary Care Provider for DepEd personnel**, supporting the health needs of teaching and non-teaching staff within the Schools Division of Nueva Vizcaya.

2. Personnel enrolled under **SHNUC as their Primary Care Provider** may avail of the following services:

a. Free Medical Consultation

b. Free Diagnostic Laboratory Tests, including but not limited to:

- Complete Blood Count (CBC) with Platelet Count
- Urinalysis
- Fecalalysis
- Sputum Microscopy
- Fecal Occult Blood Test
- Pap Smear
- HbA1c
- Lipid Profile (Total Cholesterol, HDL, LDL, Triglycerides)
- Fasting Blood Sugar (FBS)
- Oral Glucose Tolerance Test (OGTT)



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- Creatinine
- Electrocardiogram (ECG)
- Chest X-Ray

c. Essential Medicines

3. Members may avail of **essential medicines worth up to Php 20,000 per year**, depending on medical evaluation and prescription. The program aims to **reduce out-of-pocket medical expenses and encourage preventive health care among personnel.**

4. Personnel who wish to enroll in the **PhilHealth YAKAP Program under SHNUC** are advised to follow the step-by-step process explained in the orientation video. All personnel are requested to **watch the orientation video explaining the enrollment process through the following link:**

A. <https://tinyurl.com/DepEdYAKAPguide>

5. The video guide explains the following steps:

Step 1 – Register through the eGov Application: Personnel must register in the **eGov application** and select **SHNUC as their Primary Care Provider (PCP)** under the PhilHealth YAKAP Program.

Step 2 – Accomplish the Required Forms: Two forms are required:

Form 1: YAKAP Empanelment Slip (attached in this memo)

- available in English and Filipino
- must be submitted in **hard copy**
- to be submitted to the **SHNUC Clinic or the assigned District Nurse**

Form 2: Medical History Google Form (online via google link)

- **<https://tinyurl.com/FORM2YAKAPshnuc>**
- to be accomplished **online**
- used for health profiling and consultation purposes

4. Personnel who have **successfully completed their registration under the PhilHealth YAKAP Program with SHNUC as their Primary Care Provider** may coordinate with the **School Health and Nutrition Unit** for the **scheduling of consultation and laboratory services.**

5. To ensure efficient service delivery, schools are encouraged to **consolidate the list of registered YAKAP members within their school** so that a **schedule may be arranged where all registered personnel may avail of consultation and laboratory services together.**

6. Laboratory services may be conducted through:

- Scheduled visits to the **partner laboratory facility**, or



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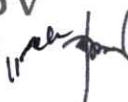
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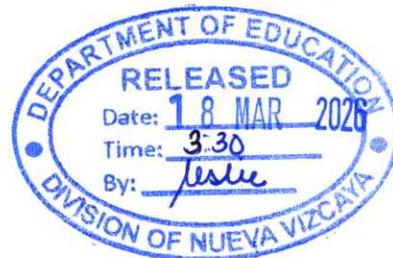
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- **School-based services through mobile laboratory support**, depending on availability and coordination.
7. School Heads are requested to **assist in organizing and coordinating the availability of teaching and non-teaching personnel during the scheduled service days.**
8. For further queries, kindly contact **Ryan Christopher A. Buccat, MD, Medical Officer III at 09275463220**
9. Immediate dissemination and strict compliance with this memorandum is enjoined.


ORLANDO E. MANUEL Ph.D., CESO V
Schools Division Superintendent 
03-2026-228





YAKAP Empanelment Slip (Mutual Care Agreement)

I, _____, born on _____ with PhilHealth Identification Number _____ do hereby acknowledge that I am empaneled to _____, until December 31st of _____ where I can receive my benefit entitlements under PhilHealth's Primary Care Benefit Package. I also acknowledge the following responsibilities as a beneficiary of the Primary Care Benefit Package:

1. Ensure my member data in PhilHealth is updated;
2. Provide true and accurate information to the Primary Care Clinic;
3. Actively participate in the agreed-upon care plan;
4. Inform the Primary Care Clinic of any relevant changes that might affect the provision of my care; and
5. Respect clinic protocols and treatment guidelines.

We, _____, with PhilHealth Accreditation Number _____, do hereby acknowledge that _____ is under our care until December 31, _____, and that we will provide the needed health services in accordance with the rules set by PhilHealth for its Primary Care Benefit Package. We also acknowledge the following responsibilities as a Primary Care Clinic:

1. Respect the beneficiary's rights including privacy and confidentiality;
2. Actively develop the care plan with the beneficiary;
3. Provide quality and accessible health services for the beneficiary; and
4. Ensure that the beneficiary receives their benefit entitlements aligned with the payment rules of PhilHealth's Primary Care Benefit Package.

Name of Patient/Signature

Date signed: _____

Head of Accredited PC Clinic

Date signed: _____

PCU Transaction Number