聖雅各福群會 惠澤社區藥房

Medication Subsidy Program

Application Form

(For official use only)

Application No. : _____

Date of Received: _____

Date of Approval: _____

Part 1: Program Information

Drug Name: _____

Currently on treatment: ☐ Yes (Start Day: ____ / ____ / ____ (Day/Month/Year)

☐ No (Predicted Start Day: ____ / ____ / ____ (Day/Month/Year)

Date of next medical appointment: _____ Name of the Hospital: _____

Part 2: Patient / Applicant Information

2.1 Patient Information

Chinese Name: _____ English Name: _____

Sex : Male / Female HK Identity Card No.: _____ (___)

Date of Birth: _____ No. of children: residing together: _____ not residing together: ____

Marital Status: ☐ Single ☐ Married ☐ Cohabiting ☐ Divorced ☐ Widowed

Living Status: ☐ Alone ☐ With partner ☐ With children ☐ With relatives / friends

(Please specify:_____)

Residential Address: _____ ☐ Self-owned ☐ Rented

_____

Home Telephone No.: _____ Mobile Phone No.: _____

Emergency Contact Person: _____ Emergency Contact No.: _____

Relationship with the Patient: _____

If the applicant is under any social security assistance scheme, please fill in the following information:

☐ None

☐ Comprehensive Social Security Assistance (CSSA) Scheme No.: _____

(Valid date until: _____)

☐ Old Age Allowance ☐ Old Age Living Allowance ☐ Normal / Higher Disability Allowance

☐ Community Care Fund ☐ Samaritan Fund ☐ Other Assistance (Please specify: _____)

If the applicant is not the patient, please fill in this part.

2.2 Applicant Information (If applicable)

Chinese Name : _____ English Name: _____

Sex: Male / Female

Home Telephone No.: _____ Mobile Phone No.: _____

Relationship with the Patient: _____

Part 3: Monthly Income of the Patient and Family Members Residing with the Patient

Please attach relevant supporting documents for the past 6 months.

- If married- included the patient, his/her spouse living under the same roof
- If unmarried- the patient, aged over 18, would be treated as a single person household; while the patient, aged under 18, included the patient, his/her parents

Number of Family Members Residing with the Patient (including the patient): ☐

3.1 Monthly Income of the Patient

If applicant cannot provide supporting documents, please fill in the Appendix I: Income Declaration Form.

Employment Status	**Average monthly income for the past six months (including commission / bonus, etc.) (HKD)**
☐ Full-time ./ Part-time : Name of Employer / Firm : _____ ☐ Unemployment: from _____ Month / _____ Year to _____ Month / _____ Year / Present ☐ Retired : With / Without Retirement Income ☐ Full-time Housewife (without income) ☐ Child / Student ☐ Other sources of income, e.g. family support / economic support from relatives and friends / share interest/ rentals /business profit (please specify: _____)	
Sub-total (1a)	

* If applicant cannot provide supporting documents for income proof,
please fill in [Appendix I: Income Declaration Form] in P. 8.

3.2 Monthly Income of the Family Members Residing with the Patient

Name	Age	Relationship with Patient	Employment Status	Average monthly income for the past six months (including commission / bonus, etc.) (HKD)
1.			☐ Full-time ./ Part-time Name of Employer / Firm : _____ ☐ Unemployment: from ___ Month / _____Year to ___ Month / _____ Year / Present ☐ Retired: With / Without Retirement Income ☐ Full-time Housewife (without income) ☐ Child / Student ☐ Other sources of income, e.g. family support / economic support from relatives and friends/ share interest/ rentals / business profit (please specify:_____)	
2.			☐ Full-time ./ Part-time Name of Employer / Firm : _____ ☐ Unemployment: from ___ Month / _____Year to ___ Month / _____ Year / Present ☐ Retired: With / Without Retirement Income ☐ Full-time Housewife (without income) ☐ Child / Student ☐ Other sources of income, e.g. family support / economic support from relatives and friends/ share interest/ rentals / business profit (please specify:_____)	
			Sub-total (1b)	

* If family members cannot provide supporting documents for income proof, please fill in [Appendix I: Income Declaration Form] in P. 8.

(If the space is not enough, please copy the form.)

Part 4: Assets of the Patient and Family Members Residing with the Patient

(Assets include those in Hong Kong and outside Hong Kong)

4.1 Deposits and Savings in Bank / Financial Institution

(Including Hong Kong currency, foreign currency, regular savings, checks, consolidated accounts, investments, securities, jockey betting accounts and other accounts)

Name of Account Holder (Including joint account)	Name of Bank	Bank Account Number	Present Value (HKD)
		Sub-total (2a)	

4.2 Stock / Warrants / Funds / Bonds / Other Investment scheme

Name of Holder	Investment scheme Name / Account Number and Quantity	Present Value (HKD)
	Sub-total (2b)	

4.3 Non-owner-occupied Property: Apartment/Shop / Parking Slot / Commercial Building/ Factory / Land / Others

Owner	Address	Present Value (HKD)
	Sub-total (2c)	

4.4 Savings / Investment-linked Insurance Policies (e.g. dividends, cash value of saving insurance)

Owner	Name of Insurance Company and Number of Insurance Policy	Present Value (HKD)
	Sub-total (2d)	

4.5 Household Monthly Income and Total Household Assets

	Household Monthly Income (HKD) 1a + 1b	Total Household Assets (HKD) 2a + 2b + 2c + 2d
Household Monthly Income and Total Household Assets		

Contact information of St. James' Settlement Philanthropic Community Pharmacy:

(Hong Kong Island)
Address: Rm 902, 9/F, St. James' Settlement, 85 Stone Nullah Lane, Wan Chai, HK
Tel no.: 2831 3289 Fax no.: 3104 3660

(Kowloon)
Address: Shop 7, G/F, High One Grand, 188 Fuk Wing Street, Sham Shui Po, Kowloon
Tel no.: 2389 9456 Fax no.: 3104 3621

(Kowloon)
Address: Shop C1, 12 / F, TG Place, 10 Shing Yip Street, Kwun Tong, Kowloon, HK
Tel no.: 2116 4958 Fax no.: 3104 3684

(New Territories)
Address: Room 917, 9/F, Shatin Galleria, 18-24 Shan Mei St., Fo Tan, Shatin, N.T.
Tel no.: 2116 1276 Fax no.: 3104 3601

WhatsApp：5131 3638
Website：https://charityservices.sjs.org.hk
E-mail：charityservices@sjs.org.hk (for application)

Part 5: Declaration & Agreement

St. James' Settlement Philanthropic Community Pharmacy Medication Subsidy Program
(must be completed by applicant or his/her deputy)

- I (signer) acknowledge and agree that St. James' Settlement may collect my personal data for the purpose of application for the medication subsidy program.
- I declare that the information given above is true and correct.
- If there are any changes of my family financial position after submitting the application, I will immediately inform St. James' Settlement and provide the related information.
- I understand that if I knowingly or willfully make any false statement to, withhold any information, or mislead St. James' Settlement, St. James' Settlement reserves the right to reject the application.
- I acknowledge and agree that St. James' Settlement will proceed with financial assessment for my application and understand that the application can be rejected if the assessment is failed.
- I acknowledge, understand and agree that St. James' Settlement will transfer the patient ‘s dispensing information, including patient number, hospital’s name, purchase date, purchase dose, injections’ number/ weeks, funding amount, to relevant sponsor pharmaceutical company / company / donor. However, the personal information of the patient, such as name, ID number, address, telephone number and relevant documents, will not be transferred to these parties. Personal information is kept strictly confidential.
- I understand and agree that the medication subsidy program is sponsored by pharmaceutical company / company / donor. Any adverse event will be reported to relevant pharmaceutical company or company.
- I understand that no resale, exchange or return of medications obtained from St. James' Settlement Philanthropic Community Pharmacy and no refund.
- I understand and agree that medication subsidy program comes into effective after St. James' Settlement’s approval.
- I acknowledge and agree that St. James' Settlement reserves the right to amend or terminate the medication subsidy program under any circumstances.
- All qualified applicants are entitled to a maximum of medication sponsorship for 12 months. After the valid period, applicants need to file another application with full updated certificates for re-evaluation.
- Declaration of St. James' Settlement:
    1. All personal information collected by St. James' Settlement is for assessing medication subsidy program examination. St. James' Settlement will not sell, borrow and transfer these information to other people or organization. St. James' Settlement respects and protects your personal information under Personal Data (Privacy) Ordinance requirement.
    2. Patient’s personal information and prescription will be destroyed after 2 years.

I (the signer below) agree with above terms and conditions.

_____ Patient Signature	_____ Date

(If you are not the patient, please sign the following part)I (the signer below) agree with above terms and conditions.

_____ Name of the Applicant	_____ Applicant Signature	_____ Date

Medication Subsidy Program

Checklist of Supporting Documents

Please prepare supporting documents according to your application. (For details, please refer to the Medication Subsidy leaflet)

1. Complete the application form and ***sign***.
2. Bring along the following supporting documents (only the ***copies***)
   - ☐ Patient's Identity Card
   - ☐ Identity Cards of family members residing with the patient
   - ☐ Relationship proof of the patient and the family members residing with the patient (e.g. marriage certificate, birth certificate, etc.)
   - ☐ Income proof of the patient and family members residing with the patient
   - ☐ All type of bank deposits records: Passbooks / monthly statements of the patient and family members residing with the patient from last 6 months (including savings, shares / fund, etc.)
   - ☐ Insurance documents of the patient and family members residing with the patient (including savings/ investment-linked insurance policies)
   - ☐ Local bank account of patient or recipient (with account holder and the account number)
   - ☐ Copy of the Self-financed Medication Prescription issued by Hospital Authority (if any)
   - ☐ Drug purchase invoices and receipts (if any)
3. Please ensure information on the application form and supporting documents are clear and readable. If the information is blurred and unreadable, applicant is required to hand in the application form and documents again.
4. Please ensure no page is missing, including the supporting documents.
5. St. James' Settlement will only approve the application after receiving completed application form and supporting documents. It may take four to six weeks to review the application.

Appendix I: Income Declaration Form

I _____, HKID: _____ hereby declare that:

Part A:

I ☐ am now unemployed.

I ☐ am now employed,

occupation is _____, and is paid by cash / cheque / bank transfer.

My income for the last 6 months, please read as follows:

Income of _____ (Month): HK$_____; Income of _____: HK$_____

Income of _____: HK$_____; Income of _____: HK$_____

Income of _____: HK$_____; Income of _____: HK$_____

Average of the last 6 months income: HK$_____

☐ No other bank accounts, assets in Hong Kong.

☐ No other bank accounts, assets in mainland of China and overseas.

☐ My family members and I **possess** a company or director of a company.
(Please specify: _____, and provide supporting documents.)

☐ My family members and I **do not possess** any company or director of any company.

☐ Others: _____

Part B:

All the above particulars furnished in this Declaration Form are true and correct. I understand that if I knowingly or willfully make any false statement, withhold any information, or mislead St. James' Settlement, St. James' Settlement reserves the right to reject the application.

Signature of Declarant: _____

Name of Declarant: _____

Date: _____

Appendix II: Bank Account of Recipients
(for cash allowance case only)

A. The amount of related medication subsidy will be transferred to the following bank account:

Bank Account Holder (Patient)：_____

Name of Bank ：_____

Bank Account No.：_____

B. Authorization Letter

Patient who cannot collect the related medication subsidy by his/her own bank account due to health issues/without a local bank account may authorize a representative to collect his/ her medication subsidy.

*(*Delete whichever is inappropriate)*

I, _____, authorize *Mr. / Ms. _____, to collect the related medication subsidy, information as follow:

Bank Account Holder (Representative)：_____

Relationship with the Patient ：_____

Name of Bank ：_____

Bank Account No.：_____

Contact Tel. No. of Representative：_____

Declaration:

I (the signer below) declare that the information given above is true and correct. Copy of local bank account will be attached.

_____ Authorizer(Patient)'s Signature	_____ Date