



**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: \_\_\_\_\_ Number of children: \_\_\_\_\_

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 patient 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**

Please indicate the economic status of the patient for the last 6 months:

**Patient Information:**

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

\* If applicant cannot provide supporting documents for income proof, please fill in [Appendix I: Income Declaration Form] in P. 7.

**Part 4: Total Assets of the Patient** (Assets include those in Hong Kong and outside Hong Kong)

**4.1 Deposits and Savings in Bank / Financial Institution**

(Including all 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)
<b>Sub-total (2a)</b>			

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

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

**4.3 Non-owner-occupied Properties:**

**Apartment / Shop / Parking Slot / Commercial Building/ Factory / Land / Others**

Owner	Property Address	Present Value (HKD)
<b>Sub-total (2c)</b>		

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

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

#### **4.5 Monthly Income and Total Assets of the Patient**

	<b>Average monthly income for the past six months (HKD) 1a</b>	<b>Total Assets (HKD) 2a+2b+2c+2d</b>
<b>Total Personal Income and Assets</b>		

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

(Hong Kong Island)

Address: Rm 105, 1/F, St. James' Settlement, 85 Stone Nullah Lane, Wan Chai, HK  
Tel no.: 2831 3289 Fax no.: 2834 7300

(Kowloon)

Address: Kowloon Kindness Centre, Rm 204-205, Konwall Court, 143 Lai Chi Kok Road,  
Kowloon, H.K.  
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.: 31043684

(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](mailto: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
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**(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
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## 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
  - Income proof of the patient
  - Other source of income proof of the patient
  - All type of bank deposits records: Passbooks / monthly statements of the patient  
**for the last 6 months** (including savings, shares / fund, etc.)
  - Insurance documents of the patient (including savings / investment-linked insurance policies)
  - Local bank account of patient or recipient (with name of account holder and account number)
  - Copy of the Self-financed Medication Prescription issued by Hospital Authority (if any)
  - Invoices for Sale of Medication 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.

## 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, mainland of China and overseas.

I **possess** a company or director of a company.

(Please specify: \_\_\_\_\_,  
and provide supporting documents.)

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
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