



Medication Subsidy Program

Application Form

(For official use only)

Application No. : _____

Date of Collection: _____

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

Date of Birth: _____ Number of children: _____

Marital Status: Single Married Separated Divorced Widowed

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

(Please specify: _____)

Correspondence Address: _____ Self-owned Rented

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

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

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

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

Community Care Fund Samaritan Fund

Other Assistance (Please specify: _____)

2.2 Applicant Information (If the applicant is not the patient, please fill in this part.)

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 attach relevant supporting documents. (For more details, please refer to the medication subsidy leaflet.)

3.1 Monthly Income of the Patient

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

Occupation	Monthly Income (including commission/bonus, etc.) (HKD)	Annual Income (HKD)
<input type="checkbox"/> Full-time ./ Part-time <input type="checkbox"/> Unemployment: from _____ Month/Year to _____ Month/Year / Present <input type="checkbox"/> Retired <input type="checkbox"/> Full-time Housewife (No income) <input type="checkbox"/> Child / Student <input type="checkbox"/> Other sources of income, e.g. family support/ economic support from relatives and friends/ share interest/ rentals /business profit (please specify: _____) * If applicant cannot provide supporting documents, please fill in the Appendix I: Income Declaration Form.		
Total (1a)		

Part 4: Assets of the Patient

(Including those in Hong Kong, Macao, the Mainland and overseas)

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 the Bank	Bank Account Number	Present Value (HKD)
Total (2a)			

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

Name of the Holder	Investment scheme Name/Account Number and Quantity	Present Value (HKD)
Total (2b)		

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

Owner	Address	Present Value (HKD)
Total (2c)		

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

Owner	Name of the Insurance Company and Number of the Insurance	Present Value (HKD)
Total (2d)		

4.5 Total Income and Assets of the Patient

	Total Annual Income (HKD) 1a	Total Personal Assets (HKD) 2a+2b+2c+2d
Total Personal Income and Assets		

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

Address: Shop C1, 12 / F, TG Place, 10 Shing Yip Street, Kwun Tong, Kowloon, HK

Tel no.: 2116 4958

Fax no.: 31043684

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 fill in the following information and sign:

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

Prepare supporting documents according to your application. (Please refer to the Medication Subsidy leaflet for details.)

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 from last 6 months (including savings, shares / fund, etc.)
 - Insurance documents of the patient (including 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)
 - 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 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.

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

Bank Account Holder (Representative) : _____

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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