仁濟永強全癱病人基金申請表

Application Form for Yan Chai Tetraplegic Fund

地址：荃灣仁濟街 7-11 號仁濟醫院 C 座 10 樓仁濟醫院董事局

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2020 年資助申請
Grant for 2020

保密文件 **Confidential**

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檔案編號 Case No.：_____

甲部 Section A

1. 申請人個人資料 (全癱病人)
Particulars of Applicant (Tetraplegic patient)

中文姓名 *Name in Chinese*	英文姓名 *Name in English*
出生日期 (日/月/年) *Date of birth (dd/mm/yy)* / /	香港身份證號碼 *HKID card no.* ( )
性別 *Sex* ☐男 *Male* ☐女 *Female*	婚姻狀況 *Marital Status* ☐單身 *Single* ☐已婚 *Married* ☐同居 *Cohabited* ☐分居 *Separated* ☐離婚 *Divorced* ☐鰥寡 *Widowed*
住宅電話 *Home telephone no.*	手提電話 *Mobile no.*
住址 *Residential address*	
電郵地址 *Email address*	
職業 *Occupation*	每月工作收入 *Monthly working income* $
機構名稱 *Company name*	機構地址 *Company address*

其他收入 *Other income*：

☐退休金/長俸 *Retirement benefits/Pensions* $ _____ (每月金額 *Amount per month*)	☐從家人、親戚或朋友等收取的金錢 *Income from family members, relatives, friends, etc.* $ _____ (每月金額 *Amount per month*)
☐長者生活津貼/高齡津貼/傷殘津貼 *Old age living allowance/Old age allowance/Disability allowance* $ _____ (每月金額 *Amount per month*)	
☐慈善基金 *Charitable fund* (近 6 個月的收款紀錄 *Record(s) in the past 6 months*) 基金名稱 *Name of charitable fund(s)* _____ 最近 6 個月收取總額 *Received amount in the past 6 months* $ _____ 備註 *Remarks* _____	
☐綜合社會保障援助 *CSSA* 檔案編號 *Case no.* _____	☐其他每月收益 *Other monthly income* $ _____ (來源 *Source* _____)

現時居住在 *Currently living at*：☐家 *Home* ☐醫院 *Hospital* ☐院舍 *Institution*
☐其他 *Others* (註明 *Please specify*：_____)

2. 家屬資料
Particulars of Family Members

姓名 *Name*	年齡 *Age*	性別 *Sex*	與申請人關係 *Relationship with the applicant*	職業 *Occupation*	每月收入 *Monthly income*	「綜援」受助人? *CSSA recipient?*	與申請人同住? *Whether residing with the applicant?*
						☐是 *Yes* ☐否 *No*	☐是 *Yes* ☐否 *No*
						☐是 *Yes* ☐否 *No*	☐是 *Yes* ☐否 *No*
						☐是 *Yes* ☐否 *No*	☐是 *Yes* ☐否 *No*
						☐是 *Yes* ☐否 *No*	☐是 *Yes* ☐否 *No*
						☐是 *Yes* ☐否 *No*	☐是 *Yes* ☐否 *No*
				合共 *Total*	**$**		

3. 住所資料
Accommodation Information

☐公營租住房屋 *Public rental housing*

每月租金 *Monthly rent* $ _____

☐私營租住房屋 *Private rental housing*

每月租金 *Monthly rent* $ _____

☐自置居所 *Self-owned property*

按揭 *Mortgage (*如有 *if applicable)*：

→ 每月供款 *Monthly mortgage payment* $ _____

☐居所由僱主提供 *Provided by employer*

詳情 *Details* _____

☐免租 *Rent free*

詳情 *Details* _____

☐其他 *Others*

詳情 *Details* _____

4. 資產 (申請人與同住家屬)
Capital Assets (Applicant & family members living under the same roof)

*(*填上的內容以遞交此申請表時最近資料為準。 *Please provide the information up to the date of submitting this application form.)*

現金 *Cash in hand*

總額 *Total amount* $ _____

股票、股份的投資及易於變換現金的財產 *Investments in stocks, shares and readily liquidated assets*

詳情 *Details* _____

_____

總估值 *Total estimated value* $ _____

非自住物業 *Non-owner occupied property*

地址 *Address* _____ 總估值 *Total estimated value* $ _____

5. 儲蓄及定期存款 (申請人與同住家屬)
Savings & Fixed Deposits (Applicant & family members living under the same roof)

帳戶持有人姓名 *Name of account holder*	銀行名稱 *Bank name*	帳戶號碼 *Account number*	最近結餘 *Recent balance* $	結餘日期 *Date of the balance*
		合共 ***Total***	**$**	

6. 申請人每月用在醫療及復康的經常支出
Applicant's Regular Monthly Expenditure in Medical and Rehabilitation Items

項目類別 (如醫療消耗品、醫療費、僱用照顧者開支、儀器保養費、特別膳食、外出求診等) *Nature of essential medical and rehabilitation items (e.g. purchase of medical consumables, medical charges, carer expenses, maintenance of equipment, special diet, transport to and from clinic/hospital, etc.)*	每月平均支出 *Average monthly expenditure*
a)	
b)	
c)	
d)	
e)	
f)	
合共 ***Total***	**$**

7. 最近申請「仁濟永強全癱病人基金」紀錄 (如適用)
Records of Recent Application for Yan Chai Tetraplegic Fund (if applicable)

年份 *Year*	摘要 *Description*	受助金額 *Amount* $
2016		
2017		
2018		
2019		

首次申請「仁濟永強全癱病人基金」的年份 *First Year of Application for Yan Chai Tetraplegic Fund*：_____(年 *Year*)

8. 申請項目
Types of Application

請提供醫生或治療師的補充文件，以支持以下的申請。

Please provide supplementary document(s) from medical officer or therapist to support the following application(s).

8.1 醫療 / 復康用具 *Medical / Rehabilitation appliance* (請提供報價資料 *Please provide quotation(s)*)

報價要求 *Quotation requirement*：	
申請項目 *Application item*	報價單數目 *Number of quotation(s)*
≦ $5,000	1 *quotation*
> $5,000 - $30,000	2 *quotations*
> $30,000 - $60,000	3 *quotations*
> $60,000	4 *quotations*

申請項目 *Application item(s)*	金額 *Amount*
a)	
b)	
c)	
d)	
e)	
合共 *Total*	$

8.2 臨時津貼 *Temporary allowance*

如個人照顧、暫顧服務、醫療消耗品等。

Temporary allowance in coping with special needs, e.g. personal helper, occasional care, medical consumable items, etc.

申請項目 *Application item(s)*	**每月金額 *Monthly amount***
a)	
b)	
c)	
d)	
e)	
f)	
每月總共 *Monthly total*	**$**

8.3 家居改裝費用 *Home modifications expenses*

申請項目 *Application item(s)*	**金額 *Amount***
a)	
b)	
合共 *Total*	**$**

8.4 其他申請 *Others*

申請項目 *Application item(s)*	**金額 *Amount***
a)	
b)	
合共 *Total*	**$**

9. 申請原因
Reasons for Making Application

10. 義務工作
Volunteer Service

「仁濟永強全癱病人基金」的每分每毫都是靠籌款而來，倘你獲得資助，你願意義務參與「基金」的宣傳及籌募活動嗎？

Every dollar of the Yan Chai Tetraplegic Fund comes from donations and successful applicants may be invited to attend the fund-raising events. Would you come and join us as you were granted?

☐我願意 *Yes, I do. (* ☐ 刊物 *publication* / ☐ 單張 *leaflet* / ☐ 電視節目 *TV programmes* / ☐ 電台節目 *Radio programmes* / ☐ 報章 *Newspaper* / ☐ 社交媒體 *Social media*)

☐我不願意 *No, I don't.*

11. 收取津貼 (只適用於領取臨時津貼)
Receiving subsidy (Applicable to receiving temporary allowance)

用以收取臨時津貼的銀行帳戶號碼 (請提供顯示帳戶持有人的英文姓名及帳戶號碼的月結單/存摺副本)

Bank account number for receiving subsidy (Please provide copy of the monthly bank statement/passbook which shows the holder's english name and the account number.)

帳戶持有人的英文姓名 *Name of account holder*	銀行名稱 *Name of bank*	帳戶號碼 *Account number*

醫療器材的資助一般是以支票發放，不會存入銀行戶口。

Grant for any medical/rehabilitation appliance will be in the form of cheque payable to the respective supplier.

12. 聲明
Declaration

本人謹此聲明，所呈報之資料均屬真確及並無遺漏，並接受「申請須知」的所有內容及受其約束。

I hereby declare that the information given herein is true, correct and complete. I accept the "terms and conditions" of the Yan Chai Tetraplegic Fund and agree to be bound by them.

_____ (_____) _____

申請人簽署 *Signature of applicant* 姓名 *Name* 日期 *Date*

如申請人年齡在 18 歲以下，申請表須由申請人的父母或監護人簽署。

If an applicant is aged below 18, parent or legal guardian should act on his behalf to sign the application form.

13. 備忘
Checklist

在遞交申請之前，請檢查以下事項 *Before submitting your application , please check if you have:*

- ✓ 已填妥的申請表格 *complete the application form*
- ✓ 附上申請須知內所要求提交的文件副本 *supplies copies of documents stated in the terms and conditions*
- ✓ 已簽署申請表及填上日期 *signed and dated the application form*

請將填妥之表格及有關文件於 2019 年 10 月 15 日或之前交回「仁濟永強全癱病人基金」。

Please return the completed application form with all required documentation to "Yan Chai Tetraplegic Fund" on or before 15 October 2019.

乙部 Section B

如非有合理理由，此部份只供醫務社工填寫。倘填寫此部份時有疑問，請與本基金職員聯絡。

If there is no reason, this part should be completed by medical social worker only. If you have any enquiries about this part, please contact us.

14. 轉介機構評估及推薦 (由轉介機構填寫)
Assessment & Recommendations by Referring Agency (to be completed by referring agency)

申請人的個案背景 *Applicant's case background*

申請人的活動能力及日常生活活動 *Applicant's mobility and activities of daily living(ADL)*

轉介原因 *Reason for making referral*

15. 轉介機構
Referring Agency

機構及辦事處名稱 *Name of agency and office*	
推薦人姓名 *Name of recommending officer*	職銜 *Position*
電話 *Telephone no.*	傳真 *Fax no.*
地址 *Correspondence address*	
推薦人簽署 *Signature of recommending officer*	日期 *Date*

丙部 Section C

(由轉介機構給予申請人的主診醫生填寫 to be completed by Medical Officer of the applicant)

Medical Assessment Form
Application for Yan Chai Tetraplegic Fund

Name of Patient:_____ HKID No.:_____(___)

Yan Chai Tetraplegic Fund provides assistance for tetraplegic patients with spinal injury at or above level 5 of cervical spine or equivalent disability. This is to refer the above-named to you for your recommendation of application for Yan Chai Tetraplegic Fund. Please kindly give your assessment.

1. Nature of patient's present illness: _____

   _____

   Description of disabilities: _____

   _____

   _____

   _____

   Is patient having the following functional disability?

	Yes	No
a. Bed mobility assisted by others and by equipment	☐	☐
b. Bowel and bladder routine are totally dependent	☐	☐
c. Bathing is totally dependent	☐	☐
d. Wheelchair transfers require assistance of one person with or without transfer board	☐	☐
e. Wheelchair mobility requires powered wheelchair	☐	☐

2. The patient requires constant care from others?
   ☐ No ☐ Yes →Duration of requiring constant care: ☐ Permanent
   ☐ Temporary → No. of _____months

3. Is this patient with spinal injury at or above level 5 of cervical spine or equivalent disability?
   ☐ No ☐ Yes

4. Comments/recommendations

   _____

   _____

   _____

   _____

Name of Medical Officer: _____

Date: _____ _____

(Authorized signature with chop)

☐ Put a "✓" in appropriate boxes