



# 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  
Address : 10/F., Block C, Yan Chai Hospital, 7-11 Yan Chai Street, Tsuen Wan  
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2018 年資助申請  
Grant for 2018

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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 <i>Name in Chinese</i>	英文姓名 <i>Name in English</i>
出生日期 (日/月/年) <i>Date of birth (dd/mm/yy)</i> / /	香港身份證號碼 <i>HKID card no.</i> ( )
性別 <i>Sex</i> <input type="checkbox"/> 男 <i>Male</i> <input type="checkbox"/> 女 <i>Female</i>	婚姻狀況 <i>Marital Status</i> <input type="checkbox"/> 單身 <i>Single</i> <input type="checkbox"/> 已婚 <i>Married</i> <input type="checkbox"/> 同居 <i>Cohabited</i> <input type="checkbox"/> 分居 <i>Separated</i> <input type="checkbox"/> 離婚 <i>Divorced</i> <input type="checkbox"/> 鰥寡 <i>Widowed</i>
住宅電話 <i>Home telephone no.</i>	手提電話 <i>Mobile no.</i>
住址 <i>Residential address</i>	
電郵地址 <i>Email address</i>	
職業 <i>Occupation</i>	每月工作收入 <i>Monthly working income</i> \$
機構名稱 <i>Company name</i>	機構地址 <i>Company address</i>
其他收入 <i>Other income</i> :	
<input type="checkbox"/> 退休金/長俸 <i>Retirement benefits/Pensions</i> \$ _____ (每月金額 <i>Amount per month</i> )	<input type="checkbox"/> 從家人、親戚或朋友等收取的金錢 <i>Income from family members, relatives, friends, etc.</i> \$ _____ (每月金額 <i>Amount per month</i> )
<input type="checkbox"/> 長者生活津貼/高齡津貼/傷殘津貼 <i>Old age living allowance/Old age allowance/Disability allowance</i> \$ _____ (每月金額 <i>Amount per month</i> )	
<input type="checkbox"/> 慈善基金 <i>Charitable fund</i> (近 6 個月的收款紀錄 <i>Record(s) in the past 6 months</i> ) 基金名稱 <i>Name of charitable fund(s)</i> _____ 最近 6 個月收取總額 <i>Received amount in the past 6 months</i> \$ _____ 備註 <i>Remarks</i> _____	
<input type="checkbox"/> 綜合社會保障援助 <i>CSSA</i> 檔案編號 <i>Case no.</i> _____	<input type="checkbox"/> 其他每月收益 <i>Other monthly income</i> \$ _____ (來源 <i>Source</i> _____)
現時居住在 <i>Currently living at</i> : <input type="checkbox"/> 家 <i>Home</i> <input type="checkbox"/> 醫院 <i>Hospital</i> <input type="checkbox"/> 院舍 <i>Institution</i> <input type="checkbox"/> 其他 <i>Others</i> (註明 <i>Please specify</i> : _____)	

## 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?
						<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
						<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
						<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
						<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
						<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No	<input type="checkbox"/> 是 Yes <input type="checkbox"/> 否 No
合共 Total					\$		

## 3. 住所資料

### Accommodation Information

<input type="checkbox"/> 公營租住房屋 <i>Public rental housing</i> 每月租金 <i>Monthly rent</i> \$ _____	<input type="checkbox"/> 自置居所 <i>Self-owned property</i> 按揭 <i>Mortgage</i> (如有 <i>if applicable</i> ) : → 每月供款 <i>Monthly mortgage payment</i> \$ _____
<input type="checkbox"/> 私營租住房屋 <i>Private rental housing</i> 每月租金 <i>Monthly rent</i> \$ _____	
<input type="checkbox"/> 居所由僱主提供 <i>Provided by employer</i> 詳情 <i>Details</i> _____	<input type="checkbox"/> 免租 <i>Rent free</i> 詳情 <i>Details</i> _____
<input type="checkbox"/> 其他 <i>Others</i> 詳情 <i>Details</i> _____	

## 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 <i>Cash in hand</i> 總額 <i>Total amount</i> \$ _____
股票、股份的投資及易於變換現金的財產 <i>Investments in stocks, shares and readily liquidated assets</i> 詳情 <i>Details</i> _____ _____
總估值 <i>Total estimated value</i> \$ _____
非自住物業 <i>Non-owner occupied property</i> 地址 <i>Address</i> _____ 總估值 <i>Total estimated value</i> \$ _____

**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 <i>Name of account holder</i>	銀行名稱 <i>Bank name</i>	帳戶號碼 <i>Account number</i>	最近結餘 <i>Recent balance \$</i>	結餘日期 <i>Date of the balance</i>
<b>合共 Total</b>			<b>\$</b>	

**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) <i>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.)</i>	每月平均支出 <i>Average monthly expenditure</i>	
a)		
b)		
c)		
d)		
e)		
f)		
<b>合共 Total</b>		<b>\$</b>

**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 \$
2014		
2015		
2016		
2017		

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 <i>Application item</i>	報價單數目 <i>Number of quotation(s)</i>
≤ \$5,000	1 quotation
> \$5,000 - \$30,000	2 quotations
> \$30,000 - \$60,000	3 quotations
> \$60,000	4 quotations

申請項目 <i>Application item(s)</i>	金額 <i>Amount</i>
a)	
b)	
c)	
d)	
e)	
合共 <i>Total</i>	\$

**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 <i>Application item(s)</i>	每月金額 <i>Monthly amount</i>
a)	
b)	
c)	
d)	
e)	
f)	
<b>每月總共 <i>Monthly total</i></b>	<b>\$</b>

**8.3 家居改裝費用 *Home modifications expenses***

申請項目 <i>Application item(s)</i>	金額 <i>Amount</i>
a)	
b)	
<b>合共 <i>Total</i></b>	<b>\$</b>

**8.4 其他申請 *Others***

申請項目 <i>Application item(s)</i>	金額 <i>Amount</i>
a)	
b)	
<b>合共 <i>Total</i></b>	<b>\$</b>

## 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 2017 年 10 月 16 日或之前交回「仁濟永強全癱病人金」。

Please return the completed application form with all required documentation to "Yan Chai Tetraplegic Fund" on or before 16 October 2017.

## 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*

備註 (如適用) *Remarks (if applicable)*

### 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?

Table with 3 columns: Question, Yes, No. Rows include: 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