

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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2025 年資助申請
Grant for 2025

保密文件 Confidential

請勿填寫 For Official Use Only

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) / /	性別 Sex ☐ 男 Male ☐ 女 Female
身份證明文件號碼 Identity document no. ()	婚姻狀況 Marital Status ☐ 單身 Single ☐ 已婚 Married ☐ 同居 Cohabited ☐ 分居 Separated ☐ 離婚 Divorced ☐ 喪偶 Widowed
聯絡電話 Telephone no.	電郵地址 Email address
住址 Residential address	
職業 Occupation	每月工作收入 Monthly working income \$

其他收入 Other income :

☐ 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 Monthly amount)	☐ 退休金/長俸 Retirement benefits/Pensions \$ _____ (每月金額 Monthly amount)
☐ 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 Monthly amount)	☐ 綜合社會保障援助 CSSA \$ _____ (每月金額 Monthly amount)
☐ 嚴重殘疾人士特別護理津貼計劃 Special Care Subsidy Scheme for Persons with Severe Disabilities \$ _____ (每月金額 Monthly amount)	
☐ 為低收入的殘疾人士照顧者提供生活津貼計劃 Scheme on living allowance for low-income carers of persons with disabilities \$ _____ (每月金額 Monthly amount)	
☐ 嚴重肢體傷殘人士綜合支援服務 Integrated support service for persons with severe physical disabilities ☐ 租用輔助呼吸醫療儀器特別津貼 Special subsidy for renting respiratory support medical equipment \$ _____ (每月金額 Monthly amount) ☐ 購買醫療消耗品特別津貼 Special subsidy for purchasing medical consumables \$ _____ (每月金額 Monthly amount)	
☐ 其他慈善基金 Other charitable fund(s) (近 12 個月的領款紀錄 Record(s) in the past 12 months) 基金名稱 Name of charitable fund(s) _____ 最近 12 個月的領款總額 Received amount in the past 12 months \$ _____ 備註 Remarks _____	
☐ 在職家庭津貼計劃 Working Family Allowance Scheme \$ _____ (每月金額 Monthly amount)	
☐ 其他每月收益 Other monthly income \$ _____ (來源 Source _____)	

2. 家屬資料

Particulars of Household 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 ☐ 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 \$ _____
☐ 租住慈善機構營運房屋 Rental residence of charity organization 每月租金 Monthly rent \$ _____	☐ 居所由僱主/親友提供 Provided by employer/relative and friend 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 & household 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 \$ _____	非自住房業 Non-owner occupied property 總估值 Total estimated value \$ _____
車輛、土地、股票、股份的投資及易於變換現金的財產 Vehicle, land, investments in stocks, shares and readily liquidated assets 詳情及金額 Details and amount \$ _____	
保險計劃的現金價值、年金計劃的投保保費金額 Cash value of insurance policies, pre-surrender/surrender value of annuity schemes 詳情及金額 Details and amount \$ _____	
其他資產 Other assets 詳情及金額 Details and amount \$ _____	

5. 儲蓄及定期存款 (申請人與同住家屬)				
Savings & Fixed Deposits (Applicant & household members)				
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>
合共 <i>Total</i>			\$	

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	
基本的醫療與復康項目 (如醫療消耗品、醫療費、僱用照顧者開支、儀器保養費、營養奶、外出求診等。) <i>Essential medical and rehabilitation items (e.g. purchase of medical consumables, medical charges, carer expenses, maintenance of equipment, nutritional milk expenses, transport to and from clinic/hospital, etc.)</i>	每月平均支出 <i>Average monthly expenditure</i>
a)	
b)	
c)	
d)	
e)	
合共 <i>Total</i> \$	

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 \$
2025		
2024		

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	
<i>Application must be accompanied by a recommendation certifying the applicant's need issued by a medical officer, therapist or relevant professionals.</i>	
請提供由醫生、治療師或相關專業人士對以下申請項目的推薦信。	
8.1 醫療 / 復康用具 <i>Medical / Rehabilitation appliance</i> (請提供報價資料 <i>Please provide quotation(s)</i>)	
報價要求 <i>Quotation requirement</i> :	
申請項目銀碼 <i>Amount of application item</i>	須出示以下數目的報價單 <i>Number of quotation(s) required</i>
≤ \$8,000	1 份報價單 <i>1 quotation</i>
> \$8,000 - \$35,000	2 份不同供應商的報價 <i>2 quotations from different suppliers</i>
> \$35,000 - \$60,000	3 份不同供應商的報價 <i>3 quotations from different suppliers</i>
> \$60,000	4 份不同供應商的報價 <i>4 quotations from different suppliers</i>
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*

臨時津貼可用於外傭工資、暫顧服務、醫療消耗品及營養奶等。

Temporary allowance in coping with special needs, e.g. expense of domestic helper, occasional care, medical consumable items, nutritional milk, etc.

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

8.3 家居改裝費用 *Home modifications expenses*

請提供由治療師或相關專業人士對以下申請項目的推薦信。

Application must be accompanied by a recommendation certifying the applicant's need issued by a therapist or relevant professionals.

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

8.4 其他申請 *Others*

請提供由相關專業人士對以下申請項目的推薦信。

Application must be accompanied by a recommendation certifying the applicant's need issued by relevant professionals.

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

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，你願意義務參與本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* / ☐ 其他 *Others* _____)
- ☐ 我不願意 *No, I don't.*

11. 收取津貼

Receiving Subsidy

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).

病人的姓名 *Name of Patient*: _____

帳戶持有人的英文姓名 <i>English name of account holder</i>	銀行名稱 <i>Bank Name</i>	帳戶號碼 <i>Account number</i>

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，所呈報之資料均屬正確無訛，並無遺漏，本人接受「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.

申請人或監護人的簽署/指模

姓名

日期

Signature/Thumbprint of applicant or guardian

Name

Date

如申請人年齡在 18 歲以下，申請表須由申請人的監護人簽署。

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 2025 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 2025.

乙部 Section B

(由轉介機構填寫 to be completed by referring agency)

如非有合理理由，此部份只供醫務社工/醫護專業人員填寫。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 a medical social worker/medical profession only. If you have any enquiries about this part, please contact us.

14. 轉介機構評估及推薦

Assessment & Recommendations by Referring Agency

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

申請人的需要 *Needs of applicant*

轉介原因 *Reason for making referral*

15. 申請人的活動能力及日常生活活動

Applicant's mobility and Activities of Daily Living

項目 <i>Activities</i>	分數 <i>Scores</i>	內容 <i>Descriptions</i>
進食 <i>Eating</i>	10 ☐ 5 ☐ 0 ☐	自己在合理時間內(約 10 秒鐘吃一口飯)進食 <i>Independent in eating within reasonable time</i> 需別人幫忙穿脫輔具或只會用湯匙進食 <i>Needs help in cutting, wearing tools or requires modified diet</i> 無法自行取食或耗費時間過長 <i>Unable to eat without feeding or taking too much time</i>
洗澡 <i>Bathing</i>	5 ☐ 0 ☐	可獨立完成，不需別人在旁(不論是盆浴或淋浴) <i>Independent in shower or bath</i> 需別人協助 <i>Needs help</i>
個人衛生 <i>Personal Hygiene</i>	5 ☐ 0 ☐	可獨立完成洗臉、洗手、刷牙及梳頭髮 <i>Independent in cleaning face/hands/teeth/hair</i> 需別人協助 <i>Needs help</i>
穿脫衣服 <i>Dressing</i>	10 ☐ 5 ☐ 0 ☐	可自行穿脫衣服、褲子、鞋子、及輔具等 <i>Independent in dressing(including buttons, zips, laces, etc.)</i> 在別人協助下，可自行完成一半的動作 <i>Needs help but can do about half unaided</i> 需別人協助 <i>Needs help</i>
如廁 <i>Toileting</i>	10 ☐ 5 ☐ 0 ☐	可自行進出廁所，穿脫衣服及可自行清理便盆 <i>Independent on and off toilet, wiping or dressing</i> 需別人協助保持姿勢的平衡、整理使用物品及清理 <i>Needs some help in balancing or cleaning</i> 完全依賴 <i>Dependent</i>
排便/排尿控制 <i>Bowel/ Bladder Control</i>	10 ☐ 5 ☐ 0 ☐	日夜皆不會失禁 <i>Continent</i> 偶而會失禁(每週不超過一次) <i>Occasional accident (not more than once a week)</i> 不能自主排便/尿，或需使用排尿管/灌腸劑 <i>Unable to manage alone or catheterized or given enemas</i>
移位 (輪椅與床位間的移動) <i>Transferring</i> (Bed/wheelchair mobility)	15 ☐ 10 ☐ 5 ☐ 0 ☐	可獨立完成 <i>Independent</i> 需要稍微的協助(需要口頭指導或輕扶以保持平衡) <i>Minor help in transferring (verbal or physical)</i> 可自行從床上坐起來，但移位時仍需要人幫忙 <i>Major help in transferring, can sit with balance</i> 需別人協助可坐起來或需要兩人幫忙方可移位 <i>Unable to sit or need two people to transfer</i>
移動 <i>Ambulating</i>	15 ☐ 10 ☐ 5 ☐ 0 ☐	使用或不使用輔具皆可獨立行走 45 米以上 <i>Independent but may use tools for over 45 metres</i> 要稍微扶持或口頭指導方可行走 45 米以上 <i>Walk with help (verbal or physical) over 45 metres</i> 可獨自操縱輪椅(包括轉彎、進門)行走 45 米以上 <i>Wheelchair independent, including corners over 45 metres</i> 需別人協助推輪椅 <i>Immobile or need help with wheelchair</i>
上下樓梯 <i>Using stairs</i>	10 ☐ 5 ☐ 0 ☐	可自行上下樓梯(允許抓扶手、用拐杖) <i>Independent (with handrails or aids)</i> 需稍微協助或口頭指導 <i>Needs help (verbal, physical, carrying aids)</i> 無法上下樓梯 <i>Unable</i>
總分 <i>Total scores</i> :		

☐ 請在合適方格上加✓ Put a “✓” in appropriate boxes

16. 轉介機構

Referring Agency

推薦人姓名 <i>Name of recommending officer</i>	職銜 <i>Position</i>
電話 <i>Telephone no.</i>	傳真 <i>Fax no.</i>
機構及辦事處名稱 <i>Name of agency and office</i>	
地址 <i>Correspondence address</i>	
簽署及機構印章 <i>Signature with chop</i>	日期 <i>Date</i>

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 financial 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. Grateful if you would give your assessment.

1. Nature of illness and description of disabilities

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2. Is this patient with **spinal injury at or above level 5 of cervical spine or equivalent disability**?

- ☐ No (If no, it represents the applicant is not eligible to apply for financial assistance)
- ☐ Yes, the tetraplegia is **permanent**
- ☐ Yes, the tetraplegia is **temporary**, reassessment is required in _____ months

3. Is this patient currently receiving enteral feeding with nutritional milk via **gastrostomy tube** or **nasogastric tube**?

- ☐ No
- ☐ Yes, the usage is **permanent**
- ☐ Yes, the usage is **temporary**, with an estimated duration of _____ months

4. Is this patient having the following functional disability?

	Yes	No	Remarks (if applicable)
a. Bed mobility assisted by others and by equipment	☐	☐	
b. Bowel and bladder routine are totally dependent	☐	☐	
c. Bathing is totally dependent	☐	☐	
d. Wheelchair transfer requires assistance from others	☐	☐	
e. Wheelchair mobility requires powered wheelchair	☐	☐	

5. The patient requires constant care from others?

- ☐ No
- ☐ Yes, the need is **permanent**
- ☐ Yes, the need is **temporary**, with an estimated duration of _____ months

Name of Medical Officer: _____

Date: _____

(Authorized signature with chop)

☐ Put a "✓" in appropriate boxes