The Community Chest Medical Assistance Fund

Application number:

檔案編號File No.:

「HealHorizon Project」Application Form

Part A：Applicant information [Please put a「✓」in the appropriate box]

(1) Full Name：(Chinese)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (English)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2) Sex：□ Male / □ Female (3) Date of Birth：\_\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_

*yyyy mm dd*

(4) Hong Kong Identity Card number：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( )

(5) Residential address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(6) Phone：(Day time)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (other)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(7) Have you ever successfully been granted The Community Chest Medical Assistance Fund ：□ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_（Name of the organisation）

Part B：Family Financial Status

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name of family member | Age | Relationship to applicant | Occupation | | Monthly income($)^ | Asset($)# |
| 1 |  |  |  |  | |  |  |
| 2 |  |  |  |  | |  |  |
| 3 |  |  |  |  | |  |  |
| 4 |  |  |  |  | |  |  |
| 5 |  |  |  |  | |  |  |
| 6 |  |  |  |  | |  |  |
| Total： |  |  |

^Income（After MPF）

#Asset value includes：Bank deposits, cash、non-residential property, stocks and other investments

Part C：Reasons of application [If there is insufficient space, please state your reasons on a separate sheet]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Part D：Supporting documents [Please put a「✓」in the appropriate box]

|  |  |  |
| --- | --- | --- |
| 1. | Applicant HKID |  |
| 2. | Proof of residential address |  |
| 3. | Income or financial proof of applicant and family members |  |
| 4. | Others (Please specify) :  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Part E：BOKSS referrer/ other referrer (Information of NGO/School/Medical organization)

(1) Referring Organization： \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(2) Referring Department： \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(3) Address of Referring Department： \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(4) Name of Referrer：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position： \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email： \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part F：Delivery of Subsidy：(Send in the form of crossed cheque)

Payable to (Full Name of the corresponding bank account)：\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part G：Declaration

□ I hereby declare that the above information is true and correct. If there is any concealment or false reporting, the subsidy will be terminated, and I must return the money received or compensate for the loss. If the information is changed, I must notify Baptist Oi Kwan Social Service as soon as possible.

* I undertake to submit the original receipt(s) to Baptist Oi Kwan Social Service within 4 weeks after the end of the treatment service, in order to certify that the fund has been used to fulfill the designated purpose. Any remaining amount will be returned to Baptist Oi Kwan Social Service.

Name of applicant： Signature：

Signature of Parent/Guardian： (For applicant under the age of 18)

Date：

Note： According to the Personal Data (Privacy) Ordinance, the personal data collected will be used by Baptist Oi Kwan Social Service and the Community Chest Medical Assistance Fund to provide assistant service. The information collected will also be provided to relevant organizations when it is necessary to make referrals for other services. Your personal data will be treated confidentially.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

The following is to be filled out by the approving organization:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of approver |  | Name of review officer |  |
| Signature |  | Signature |  |
| Date |  | Date |  |