CHILDREN'S KIDNEY FUND
兒 童 腎 病 基 金

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『環矽酸鋯鈉資助計劃』
Subsidy for Sodium Zirconium Cyclosilicate (Lokelma)

資助申請表格
Application Form

請將填妥表格及主診醫生推薦信一併電郵至 info@childrenkidneyfund.org.hk 。正本請郵寄至以上地址
Please email the completed form together with recommendation letter from the case doctor to info@childrenkidneyfund.org.hk.
For hard copy applications, please send the documents to the captioned address by post.

1. 申請人（病童）資料
Information on Applicant (Patient)

姓名： （中）： 性別 ：
Name Chinese _____ Sex _____
（英） 出生日期 ：
English _____ Date of Birth _____
出生証明書 / 身份証號碼* (請刪去不適用者):
Birth Certificate / Identity Card No. * (Delete as Inappropriate) _____
居住地址 ：
Residential Address _____
電話 ：
_____ Tel. No. _____

2. 申請人父母／監護人資料
Information on Parent / Guardian

姓名： （中）： 性別 ：
Name Chinese _____ Sex _____
（英）： 身份証號碼 ：
English _____ Identity Card No. _____
與申請人關係 ：
Relationship with Applicant _____
聯絡地址 ：
Contact Address _____

3. 轉介醫生聲明
Declaration of the referring doctor

申請人所患疾病 ： Diagnosis of the Applicant:	
需要環矽酸鋯鈉資助原因與建議劑量: Indications of Lokelma and suggested dosage and duration of the therapy:	Indications :_____ Suggested dosage: _____ Suggested duration of the therapy: _____
以往曾用藥物與期間: Previous drug(s) used: (Please ✓)	□ Resonium A for ____ □ Resonium C for _____ □ Others (Please specify): _____

茲証明上述申請人需接受環矽酸鋯鈉資助計劃共 _____月，並推薦接受有關藥物費用資助。

This is to certify that the applicant needs to receive Sodium Zirconium Cyclosilicate (Lokelma) for ____ months. I , Dr_____, support this patient's application of drug subsidy according to the dosing suggestions above.

轉介醫生姓名 ：
Name of Referring Doctor

(中) Chinese _____

(英) English _____

簽署:
Signature _____

轉介日期:
Date of Referral _____

所屬醫院 ：
Name of Hospital _____

聯絡地址 ：
Address _____

_____

電話 ：
Tel. No. _____

4 醫務社工審核
Assessment of Medical Social Worker

申請人家庭每月總收入（港幣）:
Total Family Income (HK$)

家庭總收入與政府所訂「家庭住户每月入息中位數」比例： % of Total Family Income at MMHDI

☐ 100%或以下 100% or below

□ 100-130%之間 Between 100-130%

醫務社工姓名：(中)
Name of MSW Chinese _____

(英)
English _____

簽署：
Signature _____

認可日期：
Date of Endorsement _____

所屬醫院：
Name of Hospital _____

聯絡地址：
Address _____

_____ 電話：
Tel. No. _____

5. 申請人聲明
Applicant's Declaration

茲証實上述資料無誤。
I declare that the above information is rightful and correct.

申請人(年齡十二歲以上者) 簽署 ：
Signature of Applicant (For age 12 or above) _____

父母 / 監護人簽署 ：
Signature of Parent / Guardian _____

收款人 (基金發放支票抬頭人) 姓名 ：
Name of Cheque Recipient _____

簽署式樣 ：
Specimen Signature _____

申請日期 ：
Date of Application _____

<u>以下由基金工作人員填寫 (For Office Use Only) :</u>

收件日期 ：
Received Date _____

收件人簽署 ：
Signature of Receiving Officer _____

核准人簽署 ：
Approved by _____

日期 ：
Date _____

檔案編號 ：
Reference No. _____

備註 ：
Remarks _____

_____

附註 **IMPORTANT NOTES :**

1. 環矽酸鋯鈉資助計劃津貼，如病者家庭每月總收入於「家庭住户每月入息中位數」百分之一百或以下，資助金額為藥物費用的百份之八十五。如家庭每月總收入介乎「家庭住户每月入息中位數」百分之一百至一百三十之間，資助金額為購買藥物費用的百份之五十。如家庭每月總收入介乎「家庭住户每月入息中位數」百分之一一百三十以上，將不會受到資助。
   For patients with total family income 100% of the Median Monthly Domestic Household Income (MMDHI) or below, subsidy level of the Lokelma Subsidy is 85% of the drug cost. For those with total family income between 100-130% of MMDHI, the subsidy level is 50% of the drug cost. For those with total family income above 130% of MMDHI, no subsidy would be approved.

2. 申請人年齡必須在 **19** 歲或以下，由醫院醫生推薦，並經醫務社工審核家庭收入。
   Age of the applicant must be 19 years or below, with recommendations from hospital doctor and assessment on family income by medical social worker.

3. 治療應在批准日期後 **2** 個月內開始。視乎資格而定，每項申請最多可獲得 **12** 個月的資助。
   Treatment should be started within 2 months of the approval date. Subjected to eligibility, up to 12-month of subsidy could be approved for each application.

4. 申請人須保留購買後的收據，建議每三個月向兒童腎臟基金會提交收據。
   Applicants have to keep the receipts after purchase and suggested to send the claim to Children's kidney fund every three months.