CHILDREN'S KIDNEY FUND
兒 童 腎 病 基 金

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Tel ：2369 4928
Website: http://www.childrenkidneyfund.org.hk

『阿托珠單抗資助計劃』
Subsidy for Obinutuzumab

資助申請表格
Application Form

請將填妥表格電郵至 info@childrenkidneyfund.org.hk ，並將正本寄至以上基金郵遞地址。
Please email the completed form to info@childrenkidneyfund.org.hk, with a hard copy mailed to the Fund 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 _____
聯絡電話：(日) (夜)
Tel. No. Daytime _____ Evening _____

3. 轉介醫生聲明

Declaration of the referring doctor

申請人所患疾病 ： Diagnosis of the Applicant:	
需要阿托珠單抗*治療原因: Indications of Obinutuzumab: (Please ✓)	☐ Nephrotic Syndrome : ☐ Steroid Resistant / ☐ Steroid Dependent ☐ Refractory Lupus Nephritis ☐ Others (Please specify) _____
以往曾用藥物： Previous drug(s) used: (Please ✓)	☐ Steroid ☐ Cyclosporine A ☐ MMF ☐ FK506/Tacrolimus ☐ Cyclophosphamide [___ mg for___ doses before, start date_____] ☐ Rituximab* [___ mg for ___ doses before, start date _____] ☐ Others (Please specify) _____

*Mandatory to fill for application of Obinutuzumab

以前有否接受兒童腎病基金資助？

Whether the applicant has received subsidy from Children's Kidney Fund before?

☐ 有 Yes ☐ 沒有 No

如「有」，請填下表:

If yes, please fill in the following table --

以往接受本基金會贊助利妥昔單抗/生物仿製藥的紀錄： Previous applications of Rituximab /biosimilar subsidy approved by Children's Kidney Fund	申請日期: Date of application	1) _____	2) _____	3) _____	4) _____	5) _____
	總劑量: Total Dosage	_____ mg	_____ mg	_____ mg	_____ mg	_____ mg
以往接受本基金會贊助阿托珠單抗的紀錄： Previous applications of Obinutuzumab subsidy approved by Children's Kidney Fund	申請日期: Date of application	1) _____	2) _____	3) _____	4) _____	5) _____
	總劑量: Total Dosage	_____ mg	_____ mg	_____ mg	_____ mg	_____ mg

茲証明上述申請人需接受阿托珠單抗治療，此次治療每次藥量為 _____ mg.，共 _____次，推薦接受有關藥物費用資助。

This is to certify that the applicant needs to receive Obinutuzumab treatment of _____ mg for_____ times for this course of treatment. I support this patient's application of drug subsidy according to the dosing suggestions above.

轉介醫生姓名 ： (中) 簽署:
Name of Referring Doctor Chinese _____ Signature _____
(英) 轉介日期:
English _____ Date of Referral _____

所屬醫院及地址 ：
Name of Hospital & Address _____

電話 ：
Tel. No. _____

4. 付款辦法

☐ 申請人先向醫院繳付費用，再提交醫院藥費收據正本，領取基金資助
Reimbursement on production of official receipts from the hospital

☐ 由基金向醫院直接繳付有關費用
The Fund to settle the cost directly with the hospital

5. 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% ☐ 130%以上 Above 130%

醫務社工姓名：（中） (英）
Name of MSW Chinese _____ 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. _____

6. 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 _____

申請日期 ：
Date of Application _____

簽署式樣 ：
Specimen Signature _____

以下由基金工作人員填寫 **(For Office Use Only) :**

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 ：
NOTES

1. 『阿托珠單抗資助計劃』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。
   For patients with total family income 100% of the Median Monthly Domestic Household Income (MMDHI) or below, subsidy level of the Rituximab Treatment 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.

2. 『阿托珠單抗』的最高資助藥物量為每年一劑。
   For Obinutuzumab, maximum subsidy is one dose per calendar year.

3. 家庭每月總收入在「家庭住户每月入息中位數」百分之一百三十以上，將不獲資助。
   For patients with total family income above 130% of the Median Monthly Domestic Household Income (MMDHI), no subsidy would be approved.

4. 申請人年齡必須在 21 歲或以下，由醫院醫生推薦，並經醫務社工審核家庭收入。
   The applicant's age must be 21 years or below, with recommendations from a hospital doctor and an assessment of family income by a medical social worker.

5. 每次申請的有效期為批核後的兩個月。
   Each application is only valid for 2 months after it is approved.