# CHILDREN'S KIDNEY FUND
# 兒 童 腎 病 基 金

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## 『利妥昔單抗/阿托珠單抗資助計劃』
## Subsidy for Rituximab (or its Biosimilar) or 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 _____
電郵地址：
Email 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：<br>Diagnosis of the Applicant: | |
| 需要利妥昔/阿托珠 *(*請刪除不適用者)* 單抗治療原因:<br>Indications of Rituximab / Obinutuzumab *(* please delete the inappropriate item)*：<br>(Please ✓) | ☐ Nephrotic Syndrome :<br>☐ Steroid Resistant / ☐ Steroid Dependent<br>☐ Refractory Lupus Nephritis<br>☐ Others (Please specify) _____ |
| 以往曾用藥物：<br>Previous drug(s) used:<br>(Please ✓) | ☐ Steroid ☐ MMF<br>☐ Cyclosporine A ☐ FK506/Tacrolimus<br>☐ Rituximab* ☐ Others (Please specify): _____<br>[ ___mg for___ doses before] |

*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的紀錄：<br>Previous applications of Rituximab subsidy approved by Children's Kidney Fund | 申請日期:<br>Date of application | 1) _____ | 2) _____ | 3) _____ | 4) _____ | 5) _____ |
| | 總劑量:<br>Total Dosage | _____ mg | _____ mg | _____ mg | _____ mg | _____ mg |

茲証明上述申請人需接受利妥昔/阿托珠單抗治療*(*請刪除不適用者)*，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 Rituximab / Obinutuzumab *(* please delete the inappropriate item)* 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：
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. 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 (暫不適用於阿托珠單抗申請)
Between 100-130% (not yet applicable for Obinutuzumab subsidy)

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. _____

## 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 _____

簽署式樣 ：
Specimen Signature _____

申請日期 ：
Date of Application _____

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 _____

_____

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附註：
**NOTES**

**1.** **『利妥昔單抗資助計劃』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 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。家庭每月總收入如超過此限額，將不受資助。。**
For patients with total family income 100% of the Median Monthly Domestic Household Income (MMDHI) or below, the subsidy level of the Obinutuzumab Subsidy is 85% of the drug cost. For families with income exceeding 100% of MMDHI, no subsidy would be approved.

**3.** **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.

4. **每次申請的有效期為期兩個月。**
Each application is only valid for 2 months when it is approved.