



CHILDREN'S KIDNEY FUND

兒童腎病基金

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『自動腹膜透析計劃』

Automated Peritoneal Dialysis (APD) Programme Subsidy

資助費用申請表格

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

出生證明書 / 身份證號碼* (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)

身份證號碼：

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 Referring Doctor

申請人所患疾病：

Sickness of Applicant _____

所需資助類別 (請於方格內以 ✓ 表示)

Subsidy Required [Please ✓ in the appropriate box(es)]

☐ 「自動腹膜透析計劃」喉管費用津貼

APD Cassette

茲證明上述申請人將於_____年_____月起接受「自動腹膜透析計劃」治療，本人推薦給予喉管費用資助。

This is to certify that the Applicant will start the APD treatment from _____ (mo./yr.). I would like to recommend him/her for subsidy of APD cassette. .

☐ 「自動腹膜透析計劃」首次裝置費用津貼

APD Programme Initial Set-up Cost

茲證明上述申請人將於_____年_____月起首次開始「自動腹膜透析計劃」治療，本人推薦給予計劃所需裝置費用資助，用以購買電子磅、血壓計及鈦金屬接駁器。

This is to certify that the Applicant will start the APD treatment from _____ (mo./yr.). I would like to recommend him/her for the Initial Set-up Cost for the purchase of blood pressure monitor, electronic weighing machine and Titanium adaptor/outlet port clamps.

轉介醫生姓名：

(中)

簽署：

Name of Referring Doctor

Chinese

(英)

Signature

English

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「家庭住戶每月入息中位數」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：

申請日期：

Specimen Signature _____ Date of Application _____

以下由基金工作人員填寫 (For Office Use Only) :

收件日期 :

Received Date

核准人簽署 :

Approved by

檔案編號 :

Reference No.

收件人簽署 :

Signature of Receiving
Officer

日期 :

Date

日期 :

Date

日期 :

Date

開始資助日期 :

Subsidy Starting

結束資助日期 :

Subsidy Termination

備註 :

Remarks

附註 :

NOTES

1. 『自動腹膜透析計劃』喉管費用津貼的資助金額為購買喉管費用的百份之七十五，每年最高限額為港幣貳萬圓正。申請人需先行向喉管供應商支付費用的百份之二十五，餘額由喉管供應商直接向本基金索取。

The APD Programme Subsidy is 75% of the APD cassette cost, up to a maximum of HK\$20,000 per case per calendar year. An applicant is required to pay 25% of the fee to the supplier first, and the Fund will pay the balance directly to the supplier.

2. 首次裝置費用只用以購買電子磅、血壓計及鈦金屬接駁器。申請人需先行繳付全部費用，取回收據交予本基金。本基金將以支票形式發還費用的百份之五十，最高津貼額為港幣壹仟圓正。

The Initial Set-up Cost is for the purchase of blood pressure monitor, electronic weighing machine and Titanium adaptor/outlet port clamps. An applicant has to pay all the required costs, and then submit the receipt to CKF for 50% of reimbursement, with a maximum at HK\$1,000.

3. **申請人年齡必須在 21 歲或以下，由醫院醫生推薦。**

The applicant's age must be 21 or below, with recommendation from a case doctor.