

To: Chairman
HKARF
Flat 103-106, Nam Wai House,
Nam Shan Estate, Sham Shui Po,
Kowloon
Tel. No. : (852) 2346 6336
Fax : (852) 2346 6136

Name of Hospital
Address

MSW's Recommendation Form for Patient Support Fund / Expensive Drug Support Scheme

Part I. Patient Particulars

Name of the Patient: _____
HKID No.: _____
Age: _____

or place a sticker with particulars of
patient here

Part II. Patient's Financial Assessment Result

Monthly Household Gross Income #(Total I) = \$ _____

Monthly Allowable Deductions #(Total II) = \$ _____

Disposable Capital #(Total of Part III) = \$ _____

Annual Disposable Financial Resources (ADFR)

= (\$ _____ - \$ _____) x 12 + \$ _____ = \$ _____
Monthly Household Gross Income Monthly Allowable Deductions Disposable Capital Annual Disposable Financial Resources

Annual Disposable Financial Resources (Please tick as appropriate)

Patients Support Fund

Expensive Drug Support Scheme

☐ ADFR \leq HK\$50,000.00

ADFR = HK\$ _____

☐ ADFR $>$ HK\$50,000.00

Part III. Comments/ Recommendation of MSW

Part IV. The result of the financial assessment of the above referral is as follow:

- ☐ Recommended
☐ Not Recommended

Assessed by

Name of MSW Signature Tel No. Date

Fax No.: _____ Email: _____

Endorsed by

Name of MSW Signature Tel No. Date

Fax No.: _____ Email: _____

Application Form (PSF/EDSS2) and MSW's Recommendation Form (PSF/EDSS3) will be forwarded to HKARF.