Families of S.M.A. Charitable Trust

Fund Application Form

脊髓肌肉委縮症慈善基金撥款申請表格

A. Particulars of applicant 申請人資料	
Mr. 先生 ☐ Miss 小姐 ☐ Mrs 太太 ☐ Ms 女士 ☐	
Name in English 英文姓名	Name in Chinese 中文姓名
Date of Birth (dd/mm/yy) 出生日期 (日/月/年)	H.K.I.D. Card No. 香港身份證號碼
Tel/Pager/Mobile/Fax 電話/傳呼機/手機/傳真	
Correspondence Address 通訊地址	
Relationship to S.M.A. patient (if applicable) 與 S.M.A.患者關係 (如適用者)	

B. Particulars of S.M.A. patient S.M.A.患者資料	
Mr. 先生 ☐ Miss 小姐 ☐ Mrs 太太 ☐ Ms 女士 ☐	
Name in English 英文姓名	Name in Chinese 中文姓名
Date of Birth (dd/mm/yy) 出生日期 (日/月/年)	H.K.I.D. Card No. 香港身份證號碼
Tel/Pager/Mobile/Fax 電話/傳呼機/手機/傳真	
Correspondence Address 通訊地址	
S.M.A. Type: Type I/ Type II/ Type III/ Type IV/ Unknown S.M.A.類別: 第一類/第二類/第三類/第四類/不知道	Year of diagnosis of S.M.A. 証實患上 S.M.A.年份
Name of consulting doctor & hospital 主診醫生及醫院名稱:	
Brief Description of Disabilities caused by S.M.A. 簡述傷殘程度	
Currently living at Home/Hospital/Others (please specify) 現在居於家/ 醫院/ 其他 (請註明)	

C. Family Employment History (for the past 12 months to present, including part-time employment)
家庭就業狀況 (由現在至過去十二個月，包括兼職)

Name 姓名	Age 年齡	Relationship to patient 與 S.M.A.患者關係	Occupation 職業	Name of employer 公司名稱	Position/Job Nature 職位/工作性質	From - To (yy/mm) 由(年/月)-至 (年/月)	Monthly gross income 每月收入

D. Other sources of income (e.g. public assistance from S.W. D., rental income, business profit, regular contribution from relatives/siblings, etc.) **其他收入來源 (如社署的緩助、租、生意的收入或親人的緩助等)**	
Nature 性質	Monthly amount received 每月收入
Total 總數:	

E. Regular monthly expenditure **每月經常性支出**	
Nature of essential items (e.g. housing expenses, medical expenses, maintenance & repair of equipment, etc.) 項目類別 (如屋租、醫藥支出、裝置的保養及維修等)	Average monthly expenditure 每月平均支出
Total 總數:	

F. Details of financial hardship/sickness giving rise to the application **其他的經濟困難以幫助申請**

G. Purpose for the application (e.g. for medical equipment, medical expenses, maintenance/ repair of equipment, wheelchair or cash assistance) **申請用途 (如醫療設備、醫療支出、保養及維修設備、輪椅及經濟的協助)**	
Description 摘要	Amount 金額
Total 總數:	

H. Records of previous applications (if applicable) **過去申請紀錄 (如適用者)**		
Nature (e.g. medical equipment, hospital fees, etc.) 性質 (如 醫療設備、醫藥費等)	Date (mm/yy) 日期 (月/年)	Amount 金額

I hereby declare that the information stated above is true and correct.
本人在此聲明上述資料正確無誤

Please return this form to the following address after completion:

Room 1402, 14 Floor, SUP Tower, 香港北角英皇道83號
83 King's Road, North Point, 聯合出版大廈14樓1402室
Hong Kong

Signature of applicant 申請人簽名

Date 日期

Note:
- The personal data provided in this application will be used by the Families of S.M.A. Charitable Trust for considering your application and for no other purpose.
- All information received is private and confidential.
- Families of S.M.A. Charitable Trust reserves the right to require for further documents, proof and any others verification of the information provided in this application.

備註:
- 以上資料祇作爲脊髓肌肉委縮症慈善基金審批用途
- 所有資料將絕對保密
- 脊髓肌肉委縮症慈善基金保留有關對申請者要求証明文件及審核有關資料準確性之權利