# 中华医院减免医药费申请表

## Application Form for Medical Fee Waiver

### 申请者资料 Applicant's particulars

姓名	性别	男 / 女 出生日期 Date of Birth		f Birth		
Name	Gender	Gender: Male / Female				
居民证号码 NRIC No./Iden	国籍N	国籍 Nationality		婚姻状况 Marital Status		
a.				未婚 / 已婚 / 离婚 / 丧偶 Single / Married / Divorced / Widowed		
籍贯 Dialect	种族 Race		电话 Contact Number			
地址 Address	<del>!</del>					
住房情况	」自己拥有	口租	房			59C
Housing Status	Own	R	ent			
□ 三房或以下组屋 □	] 四房组屋 [	□ 五房组屋	口 执行共管	公寓	□私人公寓	口有地住宅
3-Room or below	4-Room	5-Room	Exec. Cor	ido.	Private Condo	. Landed Property
服务机构 Organization		职业C	职业 Occupation 职位		Designation	薪金 Salary
工作地点						i i
Place of Work						

#### 家庭状况 Family Background

姓名 Name	年 龄 Age	与申请者关系 Relationship w/ Applicant	地址 Address	就读学校/服务机构 School/Organization	每月收入 Monthly Income
	N = -		s:	*	
,					

申请	理由 Reason for Application:
	是否有申请豁免登记费?如有,请注明。
Whet	ther applied for fee waiver previously? If yes, please indicate.
	否 No
8	H 110
	有 Yes
	批准期限 Period approved: 从 From至 to至
	e de la companya de
申请	者须知 Applicant to Note:
1.	申请者须呈交证件副本。
	Applicant must submit photocopy of supporting documents.
2.	请呈交估税单,公积金结单或个人及家庭工作成员的最近六个月的薪金单。
	Applicant must submit Income Tax Assessment Notice, CPF Statement or Latest 6 Months' Payslips of all working family members to certify household income.
3.	若得到其他慈善机构援助、医院医药费优惠、或属残障人士,申请时须呈交有关单位信件副本,以供酌情考虑。
	Applicant must submit photocopy of relevant documents if subsidy or assistance are obtained from other charitable organization / hospital or due to handicap.
4.	若缺乏证明文件,可向社工要求提供家庭状况资料以供参考。
	If supporting documents are not available, proof of family background from the social worker is acceptable as reference.
5.	申请过程需要 12 个工作日。
	12 working days are needed to process the application.
6.	若以上任何资料不属实,本院保留取消申请的权力。
	If any of the given information is found to be false or misleading, the organization reserves the right to disqualify the application.
声明	Declaration
本人i	谨此声明所提供的信息及提呈的资料完全属实。
	are that the information furnished on this form and documents attached are true and completed to the best of nowledge.
申请	者签名 Applicant's Signature
	日 期 Date

#### 秘书处填写 For Office Use

## 福利卡/援助卡类别 (在适当的地方画圈)

福利卡/援助卡号码 Card No.\_

日期

Types of Medical Benefit Card / Health Assist Card (Please circle the appropriate choice).

- a. 社区保健计划蓝色援助卡 (CHAS Blue Health Assist Card); 公共援助卡 (Public Assistance Card); 社区医疗福利卡 (Community Medical Benefit Card, CMB Elderly & CMB Disabled); 关怀过渡计划卡 (ComCare Transitions (CCT)); 医疗费豁免卡 (Medical Fee Exemption Card); 橙色医疗援助卡者 (Orange Health Assist Card); g. 其他,请注明 Others, Please state: \_
- h. 无福利卡/援助卡 (No Medical Benefit/Health Assist Card)

#### 病历记录参考 Medical Record

病情 / 诊断

主诊医师

Date Cor		Condition / Diagnosis	Physician-in-charge			
7/4						
		A				
			ig .			
□ 批准 Approved						
	□ 完全豁免 □ 半费					
批	批准期限 Period approved:月 Month / 年 Year					
	从 From至 to,					
□ 不批准 Not Approved						
审核者	:	批准者:				
Verified	Ву	Approved By				
校夕 / 「						
PRODUCT STORY	Signature/Date Signature /Date					