



本計劃由公益金醫療援助基金資助

This project is supported by

The Community Chest Medical Assistance Fund



香港青少年服務處
HONG KONG CHILDREN & YOUTH SERVICES

Confidential

The Community Chest Medical Assistance Fund 「Soar 2 Light Project」 Application Form

File No. : _____

(To provide emergency financial assistance to youth who are in need of psychiatric or psychological treatment service. This emergency fund can be applied all year round, and the amount of assistance will depend on the condition of individual applicant. Parent/guardian consent should be sought for applicants under age of 18. For enquiry or further information, please contact us at 2679 7557)

(I) Personal Particulars

Applicant Name: _____ (Chinese) _____ (English) Gender: _____

Date of Birth: _____ (yyyy)/ _____ (mm)/ _____ (dd) Age: _____

HKID No. (First 4 alphabet + digits): _____ Residential Address: _____

Name of School Attending : _____ Grade : _____

Name of Guardian : _____ Relationship with applicant : _____

Contact Telephone No. : _____ (Applicant) _____ (Guardian)

Psychiatric Treatment received previously :

No Yes _____ (Name of doctor/clinic)

Previous application of The Community Chest Medical Assistance Fund :

No Yes _____ (Name of organization)

(II) Family Situation

2.1 Number of family members living together (Including the applicant: _____)

2.2 Family members (Please fill in the details of all the family members living together)

| Name | Relationship with applicant | Age | Occupation | Monthly Income | Remarks |
|---------------------|-----------------------------|-----|------------|----------------|---------|
| | Applicant | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total income | | | | | |

2.3 Financial Condition (Please 「 ✓ 」 as appropriate. More than one item may be selected)

- Comprehensive Social Security Assistance
- Meet the criteria of *65%/80% of Median Monthly Household Income

*Please delete as appropriate

(III) Reasons for recommending the application by social worker

(IV) Categories of Assistance

For the service coordination, please "✓" to show preference:

| | |
|------------|-------------------------------------------------------------------------------------------------------------------|
| Categories | <input type="checkbox"/> Financial Assistance for psychiatric treatment |
| | <input type="checkbox"/> Financial Assistance for psychological treatment (Clinical Psychology/ Psychotherapy) |

(V) Declaration

- I solemnly and sincerely declare that all the information on this form is correct. I understand that the deliberate provision of false information or omission of information will render me disqualified for the application immediately, any received fund must be returned and loss incurred by the agency compensated. I undertake to report immediately to Hong Kong Children and Youth Services any changes in the particulars contained herein.
- I promise to return any unspent grant to Hong Kong Children and Youth Services for this project or The Community Chest Medical Assistance Fund after the service completed or service terminated.

➤According to the Personal Data (Privacy) Ordinance, personal data provided by you to our agency will be used by us and the Community Chest Medical Assistance Fund for providing assistance to you, and/or referral to other organizations for services if necessary. Your data will be kept confidential.

Name of Applicant : _____ **Signature :** _____ **Date :** _____

Name of Parent/Guardian : _____ **Signature :** _____ **Date :** _____
(for applicants under age of 18)

(VI) Particulars of Referrer

Name of Social Worker : _____(Mr. / Ms.)

Agency / Unit / School : _____

Telephone No. : _____(office)_____ (school)

Fax. No. : _____(office)_____ (school)

Email : _____

Referrer Name (_____) (Signature) Date: _____

Social Work Supervisor Name (_____) (Signature) Date: _____

(VII) Supporting Document (please "√" and delete as appropriate)

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Completed information in this application form | |
| 2. Copy of applicant's HKID card / Birth Certificate | |
| 3. Copy of Address proof | |
| 4. Proof of income for applicant and family members / CSSA record / Information of financial condition (The copy of family income proof can be: 1.Latest income tax demand note 2. Lastest 3 months' salary record issued by employer plus bank statement/bank passbook showing salary entry, account owner's name and account number) | |
| 5. Others (Please specify) : _____ | |

Please email the completed application form and required documents to: soar2light@hkcy.org.hk, and mail the original application form and required documents to: "Room 105-113, G/F, Tin Ming House, Tin Ping Estate, Sheung Shui, New Territories" and remark "Application for the Community Chest Medical Assistance Fund Soar2light Project". Please pay enough postage to avoid delays in receipt.

For Official use only

(VIII) Result of Application (Please the appropriate box)

Application approved, Amount HKD\$ _____

Reasons for Disapproved Cases

The application has been withdrawn by the applicant

Exceed financial limit of the fund

Successful applicant of this fund in the past

Insufficient supporting documents for assessment

Others (Please Specify) _____

Recommended by :

_____ (Signature) Date : _____
Project Social Worker Name ()

Approved by :

_____ (Signature) Date : _____
Project Supervisor Name ()

Remarks

_____ Discretion Code : _____