Penang Adventist Hospital

Operated by Adventist Hospital & Clinic Services (M) Bhd. (255697 – M)
465, JALAN BURMA, 10350 PULAU PINANG, MALAYSIA
TEL. (604) 226 1133 FAX. (604) 226- 3366

APPLICATION FORM FOR REDUCTION IN MEDICAL CHARGES FROM PENANG ADVENTIST HOSPITAL CHARITY FUND

This application form is only issued to our patients. They are worthy poor and needy who need medical skill but cannot afford to pay the full amount of medical expenses.

Application form must be filled completely by the applicant. The information provided is true and correct. Applicants must also obtain the names and signatures of two referees to certify that the information given is true. Referee should be a member of good and regular standing in Malaysia society. Please return this form to Penang Adventist Hospital in two weeks time after the day of issued.

Investigation into the circumstances and financial background of the applicant and/or patient will be carried out from all sources deemed necessary by the Hospital. Applicant should allow hospital representatives to obtain any information from any source that it may require in connection with this application without reference to the applicant.

This application form remains the property of Penang Adventist Hospital regardless of the outcome of the application. Penang Adventist Hospital reserves the right to approve or reject this application without assigning any reason.

Charity application form was issued on: ___________________________

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CHARITY APPLICATION FORM

PATIENT DATA Hospital no. ______________

Name of Patient: ____ Age: _____ Sex: _____

Address of Patient: ____

_______________________ Tel. No.: (H) _______________ Hand phone no.: ___________

Occupation of patient: ____________________________ Tel. No.: (O) ________________

Company Name & Address: ____
____

Monthly gross income: RM ______________ Other Allowances/ Income: RM __________

FAMILY DATA

Name of Spouse: __________________________ Age: _____ Tel. No. (O) ___________

Occupation of Spouse: ___________________________ Monthly Income: RM ________

Company Name & Address: ____
____

Name of Father: _________________________ Age: _____ Tel. No. (O) ______________

Occupation of Father: ___________________________ Monthly Income: RM __________

Company Name & Address: ____
____

Name of Mother: _______________________ Age: _____ Tel. No. (O) ______________

Occupation of Mother: ___________________________ Monthly Income: RM ________

Company Name & Address: ____
____

NUMBER OF CHILDREN: (If number of children more than the space provided beneath, please write at the back of the form.)

Name: ____________________ Age: ___ Occupation: ___________ Income: RM__________
Name: ____________________ Age: ___ Occupation: ___________ Income: RM__________
Name: ____________________ Age: ___ Occupation: ___________ Income: RM__________
Name: ____________________ Age: ___ Occupation: ___________ Income: RM__________
Name: ____________________ Age: ___ Occupation: ___________ Income: RM__________
Name: ____________________ Age: ___ Occupation: ___________ Income: RM__________

MONTHLY LIVING EXPENSES:

House payment/ Rental: RM_______________
Utilities bills : RM_______________
Car Payment : RM_______________
Clothing & Food : RM_______________
Child Care : RM_______________
Insurance: RM ______________________
Installment Payment: RM _____________
Transport Expenses: RM______________
Monthly Medical Expenses: RM________
SOSCO monthly Deduction: RM_______

ASSETS OWNED:

House /Apartment worth: RM________________ Motor Cycle: RM___________________
Model of Car / Van: ______________________________ How many years: _________
Model of the Second Car/Van: _____________________ How many years: _________
General Description of House /Apartment: ____

Amount of Charity that patient is requesting: RM______________________

I, __________________________________ with NRIC No. _____________________________
Am requesting this application to the Penang Adventist Hospital financial assistant or charity in the settlement of my hospital medical account.

I affirm that the above information is true and correct. I also authorize you or your representatives to obtain any information from any source that you may require in connection with this application without referring to me. This application form remains the property of Penang Adventist Hospital regardless of the outcome of this application without assigning any reason.

Date: _______________________ Signature of Patient: _____________________

/ Signature of Applicant: __________________
(Please indicate the relation to the patient): _____________

Please submit the following item together with the charity application form:
One patient's photo, A photocopy of applicant' I.C. A photocopy of patient's birth certificate, Two copies of water & electrical bills & Income Tax Borang (J)

Referee's Information

Note: Applicant must provide the names of two referees to support the application. Referee should be a member of good and regular standing in the Malaysia society and should not be related to the Applicant. (Someone of authority likes Yang Berhormat or Head of Rukun Tetangga or School Head Master/Mistress or equivalence.)

First Reference

I hereby certify that the patient/applicant is poor and is unable to settle the hospital medical bill in full.

Name: ________________________________ NRIC No. ____________________

Address: ____

______________________________ Tel. No. _____________ HP no. _________

Profession / Occupation: ______________________________

Official Stamp:

____

Do you have any relationship to the Applicant? ________ Yes _______ No

Signature: _______________________ Date: ________________________

Witnessed By: Name: ___________________________ NRIC No. ________________

Address: ____

______________________________________ Tel. No. ___________________

Profession/Occupation: __________________________

Signature: _____________________________ Date: ____________________

Referee's Information

Note: Applicant must provide the names of two referees to support the application. Referee should be a member of good and regular standing in the Malaysia society and should not be related to the Applicant. (Someone of authority likes Yang Berhormat or Head of Rukun Tetangga or School Head Master/Mistress or equivalence.)

Second Reference

I hereby certify that the patient/applicant is poor and is unable to settle the hospital medical bill in full.

Name: ________________________________ NRIC No. ____________________

Address: ____

______________________________ Tel. No. _____________ HP no. _________

Profession / Occupation: ______________________________

Official Stamp:

____

Do you have any relationship to the Applicant? ________ Yes ______ No

Signature: _______________________ Date: ________________________

Witnessed By: Name: ___________________________ NRIC No. ________________

Address: ____

_____________________________________ Tel. No. ___________________

Profession/Occupation: __________________________

Signature: ____________________________ Date: ____________________

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Doctor's Recommendation

Patient's name: ____________________________ Hospital No. __________________

Attending Doctor's name: _______________________ Tel. No. __________________

Clinic / hospital Address: ____

Final Diagnosis: ____

____

Would you recommend patient for surgery? ________ Yes _________ No

If yes, suggested date for surgery: _______________________________________

Attending Doctor's Signature: ________________________ Date: _________________

Official Stamp:

____

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