Penang Adventist Hospital
Pemohonan Bantuan Kewangan

Making a Difference in People's Lives

Operated by Adventist Hospital & Clinic Services (M) (255697-M)

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Sila sertakan satu gambar pesakit

bersize passport

No. Permohonan: ____

No Hospital: ____

APPLICATION FOR:

☐ Dr J Earl Gardner Fund ☐ Cancer Fund

☐ Patient Heart Fund ☐ Welfare Fund

☐ Lain- lain

MAKLUKAT PESAKIT *(Sila bulatkan ruangan yang diperlukan)*

Nama Pesakit: _____ Jantina : L P Umur : _____

NRIC/ No Sijil Kelahiran _____ Tarikh Lahir : __ - __ - ____

Pekerjaan: _____ Agama : _____

Bahasa yang Difahami: _____ Bangsa: _____

Nombor Tel. (Rumah) : _____ (H/P) : _____ Warganegara : _____

Alamat Rumah: _____ Status Perkhawinan: _____

_____ Pos Kod : _____ Negeri: _____

Mengapakah anda memilih Penang Adventist Hospital untuk mendapat rawatan?

_____

(Please complete the following details if Patient is under employment)

Office Name & Address: _____

Position: _____ EPF : *(circle)* Y N Monthly Salary: _____

Supervisor's Name: _____ Allowance : Y N If Yes, please indicate : _____

Position: _____ Tel No: _____

Have you previously applied to charity assist? Y N If yes, approved or rejected? A R

APPLICANT'S PARTICULARS

Name: _____ Relationship : _____

New NIRC No. : ☐☐☐☐☐☐-☐☐-☐☐☐☐ Occupation: _____

Tel No. (Home) : _____ (H/P) : _____ Monthly Income: _____

Home Address: _____ ☐ *Please tick if is same as above*

State: _____ Postal Code : _____

For Office Use Only:

Date Received: _____

Profile:

Status : ☐ Approved ☐ Reject ☐ Withdrawn ☐ Doc. Pending

Disbursement type ☐ Single ☐ Regular ☐ Term

Assessment level ☐ Level 1 Interview ☐ Level 2 Verification ☐ Level 3 Home Survey

Pending document if any:

FAMILY 'S & FINANCIAL INFORMATION (siblings, children, etc.):

Family Details:	*Patient*	*Family member 1*	*Family member 2*	*Family member 3*
Name				
Gender				
Age				
NIRC No				
Tel No				
Relationship				
Marital Status				
No. of Children				
Occupational Details:				
Occupation				
Company/School				
Monthly Salary				
Employer Name				
Contact No				
Husband/Wife's Occupation				
Husband/Wife's Salary				
Commitment(Monthly):				
Home loan/ Rental				
Car/Motorcycle loan				
Electric & Water				
HP & Internet				
Insurance				
Child Education				
Food				
Transportation/ Petrol				
Other Expenditures				
Total				

Asset Details:	**House**	**Car**	**Motorcycle**	**Others**
Units				
Type/Model				
Year Of Purchase				
Purchase Price				
Current Market Value				
Outstanding				
Monthly Installment				

Total expenses per month: RM_____
Total savings per month: RM_____
Estimated medical cost: RM_____
Monies available: RM_____
Amount applying for: RM_____

**All pre and post-operative expenses shall be borne by the applicant. The Fund shall be responsible to reimburse only the surgical amount approved by the Committee. The applicant is aware that it is not the entire financial responsibility of the Fund to bear all the pre or pro-operative expenses except when a separate application or request is made by the applicant to the Committee for their approval.*

REFEREE'S INFORMATION:

Applicant must provide names of two referees to support the application. The Referee should be a reputable and good standing citizen of Malaysia or applicant's country of residence (eg. Yang Berhormat or Head of Rukun Tetangga) and must not be related to the applicant.

First Reference:

Referee : _____

Position: _____ Tel No. : _____

NRIC No. _____

Office Address: _____

State: _____ Postal Code _____

Official Stamp & Signature

Date :

Witnessed by:

Witness : _____

Position: _____ Tel No. : _____

NRIC No. _____

Office Address: _____

State: _____ Postal Code _____

Official Stamp & Signature

Date :

DOCTOR'S RECOMMENDATION

Doctor's Name: _____

Illness Type ☐ Heart Surgery ☐ Stroke ☐ Kidney Failure

☐ Accident ☐ Others: _____

Final Diagnosis: _____

Patient recommended for surgery: ☐ Yes ☐ No

Surgery / Procedures : _____

Prognosis/Complications: _____

Official Stamp & Signature

Date :

DOCUMENTS REQUIRED:

- ☐ Patient's passport size photo- 1pc
- ☐ Copy of patient & family's NIRC/birth cert
- ☐ Recent EPF Statement of patient & immediate family
- ☐ Recent electricity & water bills-3 months (patient's house)
- ☐ Recent HP & Internet bills- 3 months (patient's house)
- ☐ Recent monthly pay slip of patient & immediate family-3 months
- ☐ If no payslip, letter of confirmation from superior, "J" form/ EA form
- ☐ Recent bank account / Credit card statement of patient & immediate family- 3 months
- ☐ Copy of sales & purchase agreement-vehicle, house, land
- ☐ Doctors' Referral Letter (If recommendation is not included)
- ☐ Medical Reports (If previously not sought treatment at PAH)
- ☐ "J" Form; EA Form
- ☐ Charitable Organization/NGO Referral letter (if applicable)
- ☐ Copies of house rental bill (if house is rented)
- ☐ Monthly installments for car and house payments (if applicable)
- ☐ Borrowing's- proof in form of bank transactions/commissioner of oath

Please take note that if complete documents are not provided to the officer, We have the right not to proceed with the application unless with good reason.

TERMS AND CONDITIONS:

The applicant must agree to all terms and conditions stated below:

Release to press or relevant authorities' information as is provided in this application form.

Use of photographs of heart/charity patients and their families for present and future use in brochures, websites, and other forms of publicity.

Committees have the right to approve/reject the application with or without informing reasons to patient/family. Approval/Rejected letter shall be issued within 14 days to applicant once final decision from the committee is obtained.

Applicants must agree to be present in press conferences/events/activities held before and after surgery.

All charity applicants must submit application form two weeks from the date form is issued out. If no sufficient document provided, MSO has the right to terminate/delay the application.

All patients must submit application form and relevant documents prior to surgery.

All information submitted must be true and accurate. If found out to be not, we shall terminate the application immediately.

Charity assistance will only be granted upon full settlement of the medical bills.

There is no refund available if the amount of charity assistance exceeds the total outstanding amount.

The fund is strictly for paying the medical bill, and shall not be transferable to any other applicant or converted to cash.

All information and documents submitted shall be treated Private & Confidential.

Except as expressly authorized by this Agreement, applicant may not use, alter, copy, distribute, transmit, or derive another cards/approval letter to be passes on to another person in order to obtain discounts from Penang Adventist Hospital. Patients shall be terminate the approval with immediate effect.

DECLARATION

I hereby authorize the committee and their appointed representatives to administer all monies collected on my behalf in relation to the above application. This includes all monies collected via news agency in relation to this application.

I also agree that excess monies (after deduction of expenses for surgery) collected on my behalf be returned to the committee to be utilized as they deem fit.

I further agree not to collect or appoint any agent to collect on my behalf any monies in relation to funds needed for my surgery from the public from this date onwards.

I grant permission to the committee and appointed representatives to publish all necessary information about myself in printed media (i.e. newspapers, brochures) in order to solicit funds from the public for financial assistance towards the surgery and/or after the surgery.

I request for financial assistance through the Penang Adventist Hospital charity for my medical expenditure at Penang Adventist Hospital

I affirm that the information contained herein is true and correct. I also authorize you or your representatives to investigate and obtain any information from any source that you may require in connection with this application without reference to me. This application form remains the property of the committee regardless of the outcome of this application without assigning any reason.

I have read the above Terms & Conditions and agree to comply. I give my permission to be investigated or provide information to Medical Social Officer, under the terms outlined above. I understand that if I have any questions or concern regarding this application procedure; I can contact medical social officer at Penang Adventist Hospital at 04-2227200.

I understand that the Authority, in its absolute and unfettered discretion, may withdraw the approval, with or without reason by giving 14 days written notice to the applicant.

Signature: ***(Applicant/Parent/Guardian)***	Signature: (***Witness***)
Name: _____	Name: _____
NRIC No.: _____	NRIC No.: _____
Date: _____	Date: _____
Telephone No.: _____	Telephone No.: _____