PRIVATE AND CONFIDENTIAL


# THE SKIPTON FUND

PO Box 50107 London SW1H 0YF Telephone: 02078081160 Email: apply@skiptonfund.org www.skiptonfund.org


## APPLICATION FORM FOR FIRST STAGE EX GRATIA PAYMENT OF £20,000 IN RESPECT OF THOSE WHO ARE/WERE REGISTERED WITH THE MACFARLANE OR EILEEN TRUSTS

### TO THE APPLICANT

Please read this page carefully before completing page 2 of the form. Please then pass it to the medical professional who you will be asking to complete the rest of the form.

## HOW TO COMPLETE THE FORM

Page 2 of the form must be completed by the person making the claim. This will either be the person infected with hepatitis C from NHS supplied blood or blood products or the person making the application on behalf of the estate of somebody who was so infected but has since died; in such an instance please enter the name of the deceased and your name as the first line of the address.

**All the rest of the form after page 2 must be completed by a medical professional, to whom you should give the form after you have completed and signed page 2.**

Ideally this would be your hepatologist but we can also accept forms completed by another medical specialist or the infected person's GP. For people applying on behalf of the estate of somebody who has died, please pass this form to either a) the consultant hepatologist who treated the deceased person b) the haematologist who treated the deceased person c) the deceased person's GP d) any other medical practitioner who knew the deceased person and has access to their medical records e) the haemophilia centre that the deceased person was registered with.

If you yourself have any records of your hepatitis C status, please give them to the medical professional who will be completing the remainder of the form. If you are applying on behalf of the estate of somebody who has died and have records regarding their hepatitis C status then please give them to the medical professional who will be completing the remainder of the form.

When the medical professional has completed the form, he or she should send it to the Skipton Fund where it will be processed. Provided the information supplied confirms your eligibility, or the eligibility of the estate, for payment, this will be made as soon as possible after the receipt of the form by the Skipton Fund.

If you have any difficulties in understanding what you should do with this application form, please telephone the Skipton Fund helpline on 0207 808 1160. In case your call has to be recorded, please be ready to leave a telephone number to which it will be possible to return your call.

## TO APPLY FOR SECOND STAGE EX GRATIA PAYMENT

Before applying for the second stage payment a successful first stage application has to have been paid to confirm eligibility. If, after receiving the first payment, you believe that you are eligible for this payment, please ask the Skipton Fund for the relevant application form.

## PART 1A - TO BE COMPLETED BY OR ON BEHALF OF THE APPLICANT

Please complete the following in block capitals:

If you are completing this form on behalf of somebody who is unable to do it themselves, please supply the following information about that person. If you are claiming on behalf of the estate of somebody who has died, please supply the name and Macfarlane or Eileen Trust Number of the deceased person along with your name and address:

Title (Mr/Ms/Mrs/other) Surname

First name Middle name/s

Address

Post Code Applicant's Eileen or Macfarlane Trust Number (if known)

What is or was your relationship to this person?

If the infected person has died and you did not supply the Skipton Fund with a copy of the death certificate during registration then please attach a copy to this form.

## PART 1B - TO BE COMPLETED BY THE APPLICANT OR THE PERSON MAKING THE APPLICATION ON BEHALF OF THE ESTATE IF THE APPLICANT IS DECEASED

**DATA PROTECTION – For living applicants only**

Your personal information will only be used by the Skipton Fund on behalf of the Department of Health (England), acting for and on behalf of the Secretary of State for Health, to check your eligibility for a payment and to administer your application. In the event of a dispute as to your eligibility for payment, your information may be disclosed to the Department of Health (England) Appeals Panel. Your information will otherwise be held in the strictest confidence and will not be shared with any other organisation.
By submitting this form to a medical professional, you consent to your medical details requested in Part 2 being supplied to the Skipton Fund and the Department of Health (England) for the purpose of administering your application. If your application is ultimately deemed to be ineligible for the ex gratia payment your information will be deleted. If you have any questions regarding the use of your information, please contact 0207 808 1160.

**Do you consent to the medical details requested in Parts 2, being supplied to the Skipton Fund?** *Delete as appropriate YES/NO*

If you have any records regarding your hepatitis C status (or that of the deceased person), please give them to the medical professional who will be completing the remainder of the form.

**For all applicants**

By signing this form I declare that the information I have given on the form is correct and complete and that I have not previously claimed for the first stage ex-gratia payment of £20,000 from the Skipton Fund on behalf of myself or, if applying in respect of a deceased person, that the estate has not previously applied for the first stage ex-gratia payment of £20,000 from the Skipton Fund. I understand that if I knowingly provide false information that I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of the information from this form to and by the Skipton Fund and NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

I wish to apply for a £20,000 ex-gratia payment.

**Signature of applicant or the person making the application on behalf of the estate if the applicant is deceased**

**Date**

**TO BE COMPLETED BY YOUR HOSPITAL DOCTOR OR GENERAL PRACTITIONER. IF APPLYING ON BEHALF OF THE ESTATE OF SOMEONE WHO HAS DIED PLEASE PASS IT TO ONE OF THE FOLLOWING a) THE HEPATOLOGIST WHO WAS TREATING THE DECEASED PERSON b) THE HAEMATOLOGIST WHO WAS TREATING THE DECEASED PERSON c) THE DECEASED PERSON'S GP d) ANY OTHER MEDICAL PRACTITIONER WHO KNEW THE DECEASED PERSON AND HAS ACCESS TO THEIR MEDICAL RECORDS e) THE HAEMOPHILIA CENTRE THAT THE DECEASED PERSON WAS REGISTERED WITH**

## NOTES TO THE MEDICAL PROFESSIONALS COMPLETING THIS FORM.

Thank you for your help with this application. Please complete either part 2A or part 2B.

In some cases this form will concern a patient who is known to you who has been infected with hepatitis C. In which case, please complete part 2A. The purposes of this form are to confirm that the patient has been chronically infected with hepatitis C, it is already known that they received treatment with NHS blood products through their registration with the Macfarlane or Eileen Trusts.

If there are questions in this form relating to your patient that you cannot answer, please consult such other medical professionals as have treated your patient who would be able to provide such answers.

In some cases this form will concern a patient who had been infected with hepatitis C but who has since died. In which case, please complete part 2B. In such a case, all the questions you are requested to answer refer to the deceased person.

Please return this form, when completed, to the Skipton Fund in the freepost envelope supplied.

Skipton Fund Limited, Freepost NAT 18555, London, SW1H 0BR

## PART 2A - TO CONFIRM THE LIVING APPLICANT'S ELIGIBILITY FOR PAYMENT

**Has an HCV antibody test ever been positive?** **YES/NO***

**Is the applicant currently PCR/RNA positive?** **YES/NO***

**If the applicant is currently PCR/RNA negative, is this as a result of past or ongoing interferon-based treatment?** **YES/NO***

**If the applicant is PCR negative is there radiological or pathological evidence that they were chronically infected after the acute phase (i.e. the first six months) of the illness has passed?**
(Relevant radiological or pathological evidence would include chronic-phase raised liver-function tests, previous consideration for treatment, liver histology or radiography, other symptoms of chronic hepatitis C.) **YES/NO***

**PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING THE ABOVE ANSWERS**

## PART 2B - TO CONFIRM THAT A DECEASED PERSON WOULD HAVE BEEN ELIGIBLE FOR PAYMENT

**Did the deceased person ever test positive for HCV antibodies?** **YES/NO***

**Was the deceased person PCR/RNA positive at the time of death?** **YES/NO***

**If at the time of death the applicant was PCR/RNA negative was this as a result of interferon-based treatment?** **YES/NO***

**If the deceased person died before tests for hepatitis C were available, was a diagnosis of non-A, non-B hepatitis associated with receipt of a blood transfusion, blood component or blood products made?** **YES/NO***

**PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING THE ABOVE ANSWERS**

*Delete as appropriate

## PART 5 - TO CONFIRM THE AUTHORITY OF RESPONDENT(S)

**How long have you known/did you know the person in respect of whom you have completed this form?**

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp
Clinician's
GMC number

**How long have you known/did you know the person in respect of whom you have completed this form?**

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp
Clinician's
GMC number

**How long have you known/did you know the person in respect of whom you have completed this form?**

**years** **months**

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp
Clinician's
GMC number

**How long have you known/did you know the person in respect of whom you have completed this form?**

years months

**Name of GP** (if relevant)

Surgery

Address

Post Code

Signature of GP

Surgery Stamp &
GMC number

By signing this form I confirm that the information contained within part 2-5 of the form is true to the best of my knowledge and belief and that if I knowingly authorise false information this may result in disciplinary action and I may be liable to prosecution. I consent to the disclosure of information from this form to and by the Skipton Fund and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and for the investigation, prevention, detection and prosecution of fraud.

**Please return the completed form to the Skipton Fund in the freepost envelope supplied**

**Thank you very much for your help in completing this form**