National Arthritis Foundation

For NAF use
Patient name: _____
Hosp/Institution: _____

Telephone number: 6227 9726 - Email to: info@naf.org.sg

PATIENT TREATMENT SUBSIDY APPLICATION FORM

WHAT SUBSIDIES ARE YOU RECOMMENDING FOR THE PATIENT? **(To be completed by Managing Specialist)**
☐ **Diagnostic Tests**
☐ **Medical Consultation – Inpatient/Outpatient bills**
☐ **Medication**
☐ **Physiotherapy Sessions**
☐ **Mobility Equipment / Orthotics**
☐ **Prosthetic Joints**
☐ **Transportation Costs**

(Please complete all sections)

A. PARTICULARS OF PATIENT (To be completed by Medical Social Worker (MSW))			
Name:		**NRIC / Birth certificate number:**	
Mr/Mrs/Mdm/Ms			
Residential status: ☐ **Singapore Citizen** ☐ **Singapore Permanent Resident** ☐ **Employment Pass Holder (Pls state nationality: _____)** ☐ **Others (Pls state type of resident pass and nationality: _____)**			
Residential Address:		**Contact Information:** **Home:** **Mobile:** **Email address:**	
Date of birth:	**Age:**	**Gender:** ☐ **Female** ☐ **Male**	**Marital status:** ☐ **Single** ☐ **Divorced** ☐ **Married** ☐ **Widowed**
Occupation			
If unemployed, since (date)			
Monthly Gross Salary (before CPF deduction)			
Reason for unemployment			

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B. MEDICAL INFORMATION (To be completed by managing specialist)			
Hospital / Institution:	☐ CGH ☐ SGH ☐ SKH	☐ KTPH ☐ TTSH ☐ WHC	☐ KKH ☐ NTFGH ☐ NUH
Name of Managing Specialist/Doctor:			
Diagnosis:			
Frequency of SOC visits:			
Adherence to medications / clinic visits:	☐ Yes ☐ No		
Work Status:	☐ Fit for normal duties ☐ Fit for light duties – state period: _____	☐ Temporarily unfit for work for _____ months ☐ Permanently unfit for work	
Assistance requested:	Therapeutic adjuncts: ☐ Diagnostic Tests ☐ Medical Consultations – Inpatient / Outpatient Bills ☐ Physiotherapy Sessions ☐ Mobility Equipment / Orthotics ☐ Prosthetic Joints ☐ Transportation Costs		
	☐ Medications		
	Non-biologic	☐ Leflunomide ☐ Cyclosporine ☐ Mycophenolate mofetil ☐ Mycophenolate sodium	☐ Tacrolimus ☐ IVIG or SCIG ☐ Others:
	Biologics (BIOSIMILAR preferred, unless justified)	☐ Anti-TNF ☐ Rituximab ☐ Tocilizumab ☐ Anakinra Remarks (if BIO-ORIGINATOR was used):	☐ Secukinumab ☐ Ustekinumab ☐ Others:
	Targeted synthetic DMARD	☐ Baricitinib ☐ Upadacitinib ☐ Others:_____	
	Please indicate medications not fulfilling MAF Plus criteria		

Please include a treatment summary, including treatment that has been tried and/or failed (Drug name, maximum dosage, and effect on control of disease):

_____

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C. BACKGROUND, SOCIAL AND FINANCIAL INFORMATION (To be completed by MSW)	
Accommodation	
Type	**Tenancy**
☐ HDB / HUDC* Flat ( ) – room ☐ Others (specify):	☐ Owner-occupied ☐ Rented ☐ Lodging with friends/relatives ☐ Others (specify):

Patient's Family Members

Family Members (including PCI of Immediate relatives living apart)	Age	Relationship to Patient	Occupation	Monthly Gross Salary before CPF deduction

Medical Social Worker's Social Report of Patient

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Financial Information

Total Family Income:	**Income (SGD)**	**Expenses (SGD)**
Patient's monthly income		
Spouse / Family Monthly Income		
Total		
Savings		
Monthly Expenses:		
Food expenses		
Home rental or installment in cash		
Conservancy charges		
Communication/internet		
Transportation		
Utilities		
Education		
Healthcare		
Helper		
Loans (specify)		
Others (specify)		
Total		

PCHI:_____

MAF subsidy eligibility for Singaporeans and PRs

Singapore Citizens

☐ 0% ☐ 40% ☐ 50% ☐ 75%

Singapore Permanent Residents

☐ 0% ☐ 20%

Non-Citizens (eligibility for NAF assistance is on a case-by-case basis)

☐ Considered - maximum quantum: _____% ☐ Not considered

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D. SUBSIDY REQUEST

☐ **New application (maximum 6 months)** ☐ **Repeat application (maximum 12 months)**

Subsidy applying for:

☐ **Medication**

Name of medication(s) for which subsidy is approved: _____

Total cost of treatment or medication(s) (over the requested subsidy duration): $_____

Recommended % of assistance and amount: _____% @ SGD = $_____per month

Period of assistance: One time / duration (no. of months): _____

Total amount of requested subsidy (over the requested subsidy duration and after MAF, MAF Plus and/or Medifund subsidy): $_____

☐ **Medical Treatment**

☐ Inpatient bill* (capped at $3,750/admission; max. of 2 admissions/yr)

☐ Outpatient bill* (covers only first and follow up subsidised consultations; excludes medication as that is covered separately above)

Recommended % of assistance:_____%

Request to also cover any of the following in the inpatient/outpatient treatments:

☐ **Diagnostic Tests***

Recommended % of assistance: _____% (capped at $260/visit; max. $1,000/yr)

Additional for advanced tests: $1,500 for scans/ year
[these include : MRI/MRA scans, nailfold capillaroscopy (max 1 /year), PET-CT scan (max 1 /year), 2DEcho(max 2 /year), lung function tests and 6 MWT (max 2 /year) or cardiac MRI (max 1 /year)) - to be accompanied by memo from Rheumatologist to indicate that these tests were ordered for assessment of the patient's condition.

☐ **Physiotherapy Sessions***

Total cost per session: _____

Recommended % of assistance and amount: _____% @ SGD = _____per month (capped at $50/session or up to $200/mth, whichever is lower)

Period of assistance: One time / duration (up to 6 months): _____

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☐ **Others**

☐ Mobility Equipment / Orthotics ☐ Prosthetic joints (subsidy amount to be reviewed based on diagnosis)

☐ Transportation Costs* (for medical appointments to hospitals only)

(Please provide NAF Transport Claim for patients, patients to submit form to NAF)

Recommended % of assistance: _____% ($20/trip; capped at $40 per return trip)

Period of assistance: Number of months: _____ (capped at 1 appointment/month)

*Subsidy applicable only if directly linked to the arthritis condition/autoimmune disease or treatment related complications/screening. Inpatient admissions are admissions related to ACTIVE disease and that a FULL DISCHARGE SUMMARY has to be attached.

For example:
If patient A gets admitted for a rheumatoid arthritis flare and has pneumonia, NAF will only cover treatment for RA flare, not pneumonia.

E. DECLARATION BY PATIENT

The patient consents to being contacted by the National Arthritis Foundation (NAF).

☐ Yes ☐ No

I declare that the above-stated information I have provided are true and accurate to the best of my knowledge. I understand that any wilful omission or suppression of information may result in unsuccessful application for assistance with immediate effect. I consent to allow National Arthritis Foundation ("NAF") to collect, use, disclose and/or process my personal data in order to process, administer, facilitate, maintain and/or manage my relationship with NAF as a member, volunteer, and/or beneficiary ("Purpose"), including communications on NAF's activities, programmes and services; donation requests; carrying out research, analysis and development activities for NAF's purposes; and making disclosures required by law or a competent authority. NAF may, for the above Purpose, disclose my personal data to its third-party service providers and/or agents, subject always to requirements under applicable law having been met.

You agree that NAF may send communications on its activities, programmes and services to you via email, text and/or WhatsApp messages, and/or post.

_____	_____	_____
Applicant's Name (Patient)	**Applicant's Signature**	**Date**

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F. TO BE COMPLETED BY HOSPITAL STAFF/MSW

In order to process this application efficiently, please ensure that you have included the following:

- ☐ Patient's social report (if not filled in on this form)
- ☐ Patient's NRIC (front & back)

Hospital	**MSW's Name**	**MSW's Signature**
Date:	**DID & HP No:**	**Email:**

For NAF use:

Application status

☐ Approved

☐ Not approved