

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
- ☐ Mobility Equipment / Orthotics
- ☐ Physiotherapy Sessions
- ☐ Prosthetic Joints
- ☐ Psychology/Psychiatric Sessions
- ☐ Transportation Costs

Conditions Covered:

- Rheumatoid Arthritis, Ankylosing Spondylitis & Spondyloarthropathies, Psoriatic Arthritis, Gout, Pseudogout, JIA, Osteoarthritis
- Mixed Connective Tissue Disease, Scleroderma (Systemic Sclerosis), Dermatomyositis, Polymyositis, Anti-Synthetase Syndrome
- Adult-Onset Still's Disease
- Systemic Vasculitis
- Behcet's Disease
- Antiphospholipid Syndrome
- Osteoporosis
- Inborn-Errors of Immunity
- IgG4-Related Disease

(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)

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

For NAF use

Patient name: _____

Hosp/Institution: _____

Monthly Gross Salary (before CPF deduction)	
Reason for unemployment	

B. MEDICAL INFORMATION (To be completed by managing specialist)

Hospital / Institution:	☐ CGH ☐ KTPH ☐ KKH ☐ SGH ☐ TTSH ☐ NTFGH ☐ SKH ☐ WHC ☐ NUH								
Name of Managing Specialist/Doctor:									
Diagnosis:									
Frequency of SOC visits:									
Adherence to medications / clinic visits:	☐ Yes ☐ No								
Work Status:	☐ Fit for normal duties ☐ Temporarily unfit for work for _____ months ☐ Fit for light duties – state period: _____ ☐ 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								
	<table border="1"> <tr> <td>Non-biologic</td> <td> ☐ Leflunomide ☐ Tacrolimus ☐ Cyclosporine ☐ IVIG or SCIG ☐ Mycophenolate mofetil ☐ Others: ☐ Mycophenolate sodium </td> </tr> <tr> <td>Biologics (BIOSIMILAR preferred, unless justified)</td> <td> ☐ Anti-TNF ☐ Secukinumab ☐ Rituximab ☐ Ustekinumab ☐ Tocilizumab ☐ Others: ☐ Anakinra Remarks (if BIO-ORIGINATOR was used): </td> </tr> <tr> <td>Targeted synthetic DMARD</td> <td> ☐ Baricitinib ☐ Upadacitinib ☐ Others: _____ </td> </tr> <tr> <td>Please indicate medications not fulfilling MAF Plus criteria</td> <td></td> </tr> </table>	Non-biologic	☐ Leflunomide ☐ Tacrolimus ☐ Cyclosporine ☐ IVIG or SCIG ☐ Mycophenolate mofetil ☐ Others: ☐ Mycophenolate sodium	Biologics (BIOSIMILAR preferred, unless justified)	☐ Anti-TNF ☐ Secukinumab ☐ Rituximab ☐ Ustekinumab ☐ Tocilizumab ☐ Others: ☐ Anakinra Remarks (if BIO-ORIGINATOR was used):	Targeted synthetic DMARD	☐ Baricitinib ☐ Upadacitinib ☐ Others: _____	Please indicate medications not fulfilling MAF Plus criteria	
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Please indicate medications not fulfilling MAF Plus criteria									

For NAF use

Patient name: _____

Hosp/Institution: _____

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

For NAF use

Patient name: _____

Hosp/Institution: _____

C. BACKGROUND, SOCIAL AND FINANCIAL INFORMATION (To be completed by MSW)

Accommodation

Type

☐ HDB / HUDC* Flat () – room

☐ Others (specify):

Tenancy

☐ 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

Patient name: _____

Hosp/Institution: _____

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

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		

For NAF use

Patient name: _____

Hosp/Institution: _____

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 other financial aids): \$ _____

☐ **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/month, whichever is lower)

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

Patient name: _____

Hosp/Institution: _____

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

☐ **Psychology/Psychiatric Sessions***

Number of visits required: _____

Total cost per visit : _____

(Full subsidy for the first 2 visits; 80% covered for subsequent visits; capped at \$1,500 per year)

☐ **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

For NAF use

Patient name: _____

Hosp/Institution: _____

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