For Project Staff Use Only	
Application Number	

New Life Psychiatric Rehabilitation Association
Psychiatric Medical Subsidy and Community Support Project
Phase V (2025-2027)
Application Form

Part A Referring Organization (Please read "Application Guidelines" carefully before filling out the application form.)

1. Name of Organization and Service Unit：_____

2. File Number (if applicable)：_____

Part B Applicant's Personal Information (Applicants under 18 years old must have the form signed by a parent or guardian)

1. Name：_____ _____ Gender: ☐ Male / ☐ Female
(Chinese) (English)

2. Date of Birth：_____ 3. Hong Kong Birth Certificate / Hong Kong Identity Card Number：_____

4. Correspondence Address：_____

5. Contact Phone Number：(Main) _____ (Other) _____

6. Suspected Mental Health Problem of Applicant：_____

7. Receiving Comprehensive Social Security Assistance (CSSA)：☐ Yes / ☐ No

8. Financial Condition of the Applicant and Household Members

Name of Applicant/ Household Members	Age	Relationship with Applicant	Occupation	Monthly Income ($)[1]	Assets ($)[2]
		Applicant		$	$
				$	$
				$	$
				$	$
				$	$
				$	$
Total Number of People：				Total Income $	

9. Receiving Service(s) from Social Welfare Department, Hospital Authority or non-governmental organizations?

☐ No □ Yes (Please fill in the table below)

Name of Applicant or Household Members	Name of Organization	Type of Service Received	Duration

[1] Income: includes wages (after deducting mandatory contributions to the Mandatory Provident Fund), remuneration for services provided, business profits, rental income, monetary assistance from the government or non-government organizations (e.g., CSSA, Old Age Living Allowance, Working Family Allowance, etc.)

[2] Assets: include cash, bank deposits, non-owner-occupied properties, investments (e.g., savings insurance, funds, stocks, etc.), and other cash-convertible properties

Part C Applicant's Public Hospital Specialist Out-patient Clinics (Psychiatry) Appointment Information

Name of Specialist Out-patient Clinics (Psychiatry): _____

Date of New Case Appointment： _____

(Please attach copy of relevant documents as proof)

Part D Applicant's Declaration and Guarantee

I (Applicant) _____ / (Parent / Guardian[3]) _____ hereby declare that I have read the application guidelines, the declaration and notes below and understand the content; all the information provided is true and complete, otherwise, I must return the approved subsidy to the "Psychiatric Medical Subsidy and Community Support Project" and the project has the right to refuse future applications from me or my family.

1. I understand and agree that the purpose of the collection of my personal data by the New Life Psychiatric Rehabilitation Association (hereinafter referred to as "the Association") is to process my service application for the Psychiatric Medical Subsidy and Community Support Project. If the information I provide is insufficient, the Association may be unable to process my application or provide services to me.
2. I agree that, for the above purpose, the Association may collect my personal data, including but not limited to obtaining relevant information from government departments, the Hospital Authority, funding bodies, other non-governmental organisations or individuals, and I consent to such parties providing the required information to the Association.
3. Unless exempted under the Personal Data (Privacy) Ordinance, I understand that I may make a written request[4] to the Head of Professional Services (Community Services), Social Work Officer or Supervisor to access or correct my personal data.
4. I agree that, for the purposes of processing this service application, providing ongoing services, case referral or handling emergency situations, the Association may, where necessary, disclose my personal data to relevant third parties, including but not limited to:
   a. Government departments, the Hospital Authority and funding bodies;
   b. Other non-governmental organisations or professionals providing medical, social or rehabilitation services, such as doctors, social workers or therapists;
   c. Other relevant parties necessary for my care or support, such as my family members, carers or school representatives.
5. I confirm that when participating in or assisting with any services or activities organised by the Association, I will assess my own health condition and participate according to my abilities. I understand that some activities may involve inherent risks (including but not limited to personal injury or property loss). I participate voluntarily and agree to assume such risks, and I undertake to comply with all relevant guidelines and on-site instructions issued by the Association and its staff.

   To the fullest extent permitted by law, if any injury or loss arises from my failure to comply with guidelines, my own negligence, or actions beyond my personal capability, the Association and its staff, agents or volunteers shall not be held legally liable. Likewise, the Association shall not be liable for losses caused by force majeure events such as extreme weather or natural disasters. Nothing in this clause is intended to exclude or limit the Association's liability for death or personal injury resulting from its negligence.

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[3] Please delete where not applicable

[4] By Email: pms@nlpra.org.hk (Please state "Request for Access or Correction of Personal Data" in the email subject)
By post: Psychiatric Medical Subsidy and Community Support Project
2/F., New Life Building, 332 Nam Cheong St., Kowloon, H.K.
(Please state "Request for Access or Correction of Personal Data" on the envelope)

6. According to the Prevention of Bribery Ordinance (Cap. 201) of Hong Kong, any person who offers, solicits, or accepts any advantage (such as money, gifts, etc.) in connection with the submission or processing of this application may commit a bribery offense. Anyone convicted of a bribery offense may be fined up to $500,000 and imprisoned for up to 7 years.
7. The association reserves all final decision rights regarding any disputes arising from the decisions made for this project and its operation.
8. In the event of any conflict or inconsistency between the Chinese and English versions, the Chinese version shall take precedence.
9. Direct Marketing Arrangement:

   The Association intends to use your personal data (including your name, contact phone number, email address and correspondence address) to provide you with the Association's latest information, including service promotions, courses, paid activities and fundraising appeals. Under the law, we may not use your personal data for this purpose without your consent.

   Please tick the following option to indicate your preference:

   [ ] **I agree** to receive the above direct marketing information from the New Life Psychiatric Rehabilitation Association.

   (You may notify the Association at any time in writing[5] or by phone[6] to request cessation of receipt of direct marketing information. This service is free of charge.)

Signature of Applicant:	
Name of Applicant:	
Hong Kong Identity Card Number of Applicant:	
Date:	
Signature of Applicant's Parent / Guardian[7,8]:	
Name of Applicant's Parent / Guardian[7,8]:	
Date:	
Signature of Witness:	
Name and Position of Witness:	
Reference Number:	
Date:	

[5] By Email: pms@nlpra.org.hk (Please indicate "Unsubscribe from Direct Marketing Information" in the email subject)
By post: Psychiatric Medical Subsidy and Community Support Project
2/F., New Life Building, 332 Nam Cheong St., Kowloon, H.K.
(Please mark "Unsubscribe from Direct Marketing Information" on the envelope)

[6] Telephone: 3552 5286

[7] Applicants under the age of 18 must have the form signed by a parent or guardian.

[8] Please delete where not applicable.

Part E Preference for Matching with Private Psychiatrist in the Program
(This section is to be filled out by the referring organization)

☐ If the applicant is approved for the subsidy, it is suggested the follow up by the private psychiatrist：

(Name)_____.

☐ If the applicant is approved for the subsidy, please match the applicant with a private psychiatrist by project's staff.

[#] This section may be completed by the referrer, the applicant, and/or the applicant's parent/guardian after discussion, **by ticking ("✓") to indicate their preferences**. The suggestions are for reference only during the matching process conducted by the project social worker, and the project reserves the final right of assignment.

Part F Referrer's Commitment to Support the Project
(This section is to be filled out by the referring organization)

Referrer _____ must commit to conducting a service needs assessment for the beneficiary and assisting in referring the beneficiary to the Integrated Community Centre for Mental Wellness or other support services in their district if the applicant is approved for subsidy. The referrer should encourage the applicant and, if applicable, their family members or caregivers to participate in at least one community support activity organized by the Project.

Part G Referring Organization / School Recommendation and Review
(This section is to be filled out by the referring organization)

<table>
<tr><td colspan="2">Our organization / school has verified the application content and
clearly understands the applicant's need for financial assistance.</td></tr>
<tr><td>1. Referrer

Signature：_____
Name：_____
(Please fill in block letters)
Title：_____
Tel No.：_____
Fax No.：_____
Email：_____</td><td>2. Review
(to be filled out by the referrer's supervisor, if applicable)
Signature ：_____
Name：_____
(Please fill in block letters)
Title：_____
Tel No.：_____
Fax No.：_____
Date：_____</td></tr>
<tr><td><u>Stamp of Organization / School</u> →</td><td></td></tr>
</table>

Part H Submission of Application Documents and Checklist
(This section is to be filled out by the referring organization)

1. The following documents MUST be submitted:

a. ☐ Completed application form with required information (Please ensure Parts E, F, and G are fully completed and stamped. The **original** should be submitted to the project office, and a **copy** should be kept by the referring organization)

b. ☐ **Copy** of Hong Kong Birth Certificate or Hong Kong Identity Card

c. ☐ **Copy** of proof of family income (recent consecutive 3 months' payslips issued by the employer for the applicant and household members, and/or a self-declaration of income, stating the amount of monthly income for the recent consecutive 3 months (method of payment), position, full-time/part-time, etc., signed by the declarant; or other documents that help with the approval process)

d. ☐ **Copy** of proof of family assets (recent consecutive 3 months' bank account statements/passbooks for the applicant and household members, showing the account holder's name and number; or other documents that help with the approval process)
* If the applicant is a CSSA recipient, only the medical fee waiver certificate (showing the applicant's name) or the approval notice for "Comprehensive Social Security Assistance" and the recent consecutive 3 months' bank account statements/passbooks showing the CSSA amount are required.

e. ☐ **Copy** of proof of new case appointment of public hospital Specialist Out-patient Clinics (Psychiatry)

f. ☐ **Copy** of proof of correspondence address, such as bank statements, CSSA notification letters, water/electricity/gas bills, etc.

2. The following documents should be submitted based on the applicant's situation

a. ☐ **Copy** of documents related to the health status of the applicant and their family members

b. ☐ Other documents that help with the approval process (Please specify：_____)

c. ☐ Is the applicant currently receiving treatment from a private psychiatrist / clinical psychologist?
☐ No □ Yes，Please provide **copy** of relevant proof documents, such as clinic receipt/referral letter, etc.
(Please specify：_____)

3. Remarks (Referrer can provide additional information that helps with the approval process, such as the relationship between the applicant and their family, economic status, etc.)

Part I Recommendation and Approval
(This section is to be filled out by the Project Officer)

The application of (the applicant) _____ for the "Psychiatric Medical Subsidy and Community Support Project" is

☐ recommended

☐ not recommended (remarks)：_____

Head of Professional Services/Supervisor/Social Work Supervisor：_____
（Signature）

Date：_____

Part J Submission Method and Contact Details

Submission Method: If submitting the application by mail, please pay sufficient postage. The mailing address is **2/F, New Life Building, 332 Nam Cheong Street, Shek Kip Mei, Kowloon**, and write the full name **"Psychiatric Medical Subsidy and Community Support Project"** on the envelope. The program does not accept applications submitted by email or fax.

Contact Details:

Psychiatric Medical Subsidy and Community Support Project
Address: 2/F., New Life Building, 332 Nam Cheong St., Kowloon, H.K.
Tel: 3552 5286
Email: pms@nlpra.org.hk
Project website: http://pms.nlpra.org.hk