Youth Diabetes Action
兒童糖尿協會

The Community Chest Medical Assistance Fund
CGM Little Rainbow Application Form
公益金醫療援助基金
CGM 小彩虹申請表格

Introduction 簡介

Good diabetes management requires self-monitoring of blood glucose multiple times a day. Before Continuous Glucose Monitor (CGM), regular finger-prick test was the only way to monitor glucose level. To ease the pain and improve life with diabetes, The Community Chest Assistance Fund will provide CGM to selected children and youth with diabetes aged 16 or below.

良好的糖尿病管理依靠每日多次的血糖測試，在連續血糖監測儀（CGM）面世前，患者只能使用手指刺針方式（俗稱「篤手指」）量度血糖。公益金將為 16 歲或以下糖尿病患者提供 CGM，讓他們得到全天候血糖監察，提高生活質素。

Eligibility 資格

- Family in need of support for children / youths with diabetes aged 16 or below.
  有需要家庭 16 歲或以下患糖尿病的兒童 / 青少年。
- Youths with diabetes who have special medical conditions and recommend by medical professional.
  患糖尿病及有特殊醫療需要並獲醫生推薦的青少年。

Methods of application 申請辦法

Complete application, referral form together with supporting documents and post or email to YDA. Financial Assistance Programme (FAP) approved applicants do not require to provide supporting documents.

申請人須填妥此表格及轉介表，並連同相關證明文件，郵寄或電郵至本會。（如已申請本會醫療用品資助，可豁免提供證明文件。）

- Mailing address: B17, 9/F, Block B, Merit Industrial Centre, 94 To Kwa Wan Road, Kowloon
  郵寄地址：九龍土瓜灣土瓜灣道 94 號美華工業中心 B 座 9 樓 B17 室
- E-mail 電郵：LittleRainbow@yda.org.hk

Format of subsidy 資助形式

CGM will be granted to successful applicants.

成功申請者將獲得連續血糖監測儀。

Enquiries 查詢

For enquiries, please contact Social Worker.

如有任何查詢，請與本會社工聯絡。

陳姑娘 (Ivy Chan) 2544 3362 (ivychan@yda.org.hk)

羅姑娘 (Hannah Lo) 2543 0555 (hannahlo@yda.org.hk)

本計劃由公益金醫療援助基金資助
This project is supported by The Community Chest Medical Assistance Fund

Youth Diabetes Action
兒童糖尿協會

The Community Chest Medical Assistance Fund
CGM Little Rainbow Application Form
公益金醫療援助基金
CGM 小彩虹申請表格

Part I - Particulars of applicant 第一部份 — 申請人資料

Name 姓名	(English) Surname	Given Name	(中)
Gender 性別	Male 男 / Female 女	Date of Birth (dd/mm/yyyy) 出生日期 (日/月/年)	/ /
Membership No. 會員號碼		Type of Diabetes 糖尿病類型	Type I 一 型 / Type II 二 型
Follow Up Hospital 覆診醫院		Year and month of Diagnosis 確診年份及月份	
Other disease (if any) 其他疾病（如有）			
School 就讀學校		Grade 就讀年級	
Contact Person 聯絡人		Relationship with applicant 與申請人關係	
Email 電郵		Telephone 電話	
Address 地址			

Please "✓" for type(s) of allowance received 請在已獲取的援助/津貼內打「✓」

☐ Applicant is currently a beneficiary of the YDA Financial Assistance Programme
申請人現正受惠於兒童糖尿協會醫療用品資助計劃（FAP）

☐ Applicant is currently a beneficiary of the Comprehensive Social Security Assistance (CSSA) Scheme
申請人現正領取綜合社會保障援助（綜援）計劃

Part II - Detail of family 第二部份 — 家庭資料

A. Particulars of family members 家庭成員資料

Family members residing with applicant 與申請人同住的家庭成員				
	Name in English 英文姓名	Name in Chinese 中文姓名	Relationship 關係	Current status# 現況#
1			父 Father	
2			母 Mother	
3				
4				
5				
6				

\# *In employment (please fill Part C) / Unemployed / Retired / Student (year of study)*
*就業（**請填 C 部份**） / 失業 / 退休 / 在學（**請註明就讀年級**）*

Marital status of parents 父母婚姻狀況			
☐ In marriage 已婚	☐ Divorced 離婚	☐ Widow/er 喪偶	☐ Other 其他

B. Accommodation status 居所類別

☐ Public housing 公共房屋：Monthly rental fee 每月租金	$
☐ Private housing 私人樓宇：Monthly rental/mortgage 每月租金/按揭供款	$
☐ Self-owned 自置	
☐ Other 其他 （Please specify 請註明）	

C. **Household income 與申請人同住的家庭成員收入**

Total income of the last 12 months 過去 12 個月期間的收入

	Name 姓名	Relationship 關係	Company 公司名稱	Position 職位	Full-time / part-time 全職/兼職	Office phone no. 辦公室電話	Annual income 全年總收入 (HK$ 港幣$)
1		父 Father					
2		母 Mother					
3							
4							
						總數 Total	

Part III - Current CGM Consumptions# 第三部份 — CGM 使用現況#

Have you been using a CGM? 曾否使用 CGM？		□ Yes 是	□ No 否
Are you currently getting CGM from Hospital Authority? 你現在是否從醫院管理局獲得 CGM？		□ Yes 是	□ No 否
Brand of CGM currently using 現使用之 CGM 品牌	□ Dexcom	□ FreeStyle Libre	□ Medtronic

YDA reserves the right to allocate the brand and no. of CGM YDA 保留分配 CGM 的數量和品牌的決定權

Part IV - Supplementary Information 第四部份 — 補充資料

e.g. Special medical needs, relatively higher HbA1c rating or other information
如特殊醫療需要、糖化血色素偏高或其他補充事項

Notes 附註

a. CGM supply will be on first-come-first-serve. 名額有限，先到先得，額滿即止。

b. YDA reserves the right to 本會有權：
   - Approve / reject an application, subject to the discretion of YDA. 批核或拒絕任何申請
   - Conduct home visit to understand the condition of the applicant's family status. 到訪申請人家庭進行家訪，了解申請人家庭狀況
   - Contact schools or employers of family household members, to authenticate the information provided on the application. Any misrepresentation and concealment of facts may lead to disqualification 聯絡申請人及其家庭成員的學校或僱主，核對填報的資料。申請人若在申請表內誤報或漏報資料，其申請資格將會被取消
   - Amend the terms or cancel this Programme at its discretion without any notice. 更改或取消本計劃而毋須作出任何通知及解釋

c. If excess supply of CGM sensors were given due to miscalculation, applicants are liable to return the excess quantity back to YDA. 倘若因計算錯誤而導致申請人獲多發放物資，申請人必須把物資退還

d. The information collected in the CGM Little Rainbow Programme is only used for program application, approval and other programme related purposes, and will not be disclosed to third parties. By submitting the application form, supporting documents and medical referral form, the applicant agrees the use of the relevant information by YDA. At the end of the programme, the above-mentioned information will be destroyed. CGM 小彩虹計劃中收集的資訊僅作計劃申請、審批及其他相關之計劃用途，不會向第三方披露。申請人遞交申請表、證明文件及醫護轉介表時，即表示同意本會使用有關資料。計劃完結時，上述有關資料將被銷毀。

Declaration 聲明

I certify that the information provided is true and complete. 本人證明以上所提供的資料屬實，正確無誤。

Signature of Parents / Guardians 家長或監護人簽署：_____

Name 姓名：_____ Date 日期：_____

Documents Checklist 所需文件清單

Please check if the required documents are attached 請檢查所需文件是否齊備	Applicant check 申請人專用	YDA check YDA 專用
Supporting documents (if applicable) 證明文件（如適用）		
- Medical proof of diabetes (e.g. copy of doctor's diagnose letters or consultation appointment slips) 糖尿病醫生證明（如醫生證明信或醫院覆診紙等之副本）		
- Proof of full-time study (e.g. copy of student handbook, or student card) 全職學生在學證明文件 （如學生手冊、學生證等之副本）		
- Proof of income for family members within the same household (e.g. copy of salary statement, tax return forms of the last 12 months, or income declaration form) 與申請人同住家庭成員之收入證明（如過去 12 個月期間的糧單、税單等之副本或收入聲明書）		
- Proof of monthly housing rental fee / mortgage payment (e.g. copy of house rent contract, house rent payment receipt) 居所的每月租金或按揭供款證明（如租約、付款收據等之副本）		
- Proof of the applicant's sibling study (if applicable) 兄弟姊妹在學證明文件（如適用）		
- Proof of applicant having other disease(s) if applicable (e.g. copy of consultation appointment slips) 申請人的其他病患證明（如適用）（例如醫院覆診紙之副本）		
- Proof of family members residing with the applicant having chronic illness(es) if applicable (e.g. copy of consultation appointment slips) 同住家庭成員的長期病患證明（如適用）（例如醫院覆診紙之副本）		
Appendix I 附件一 Referral from by medical professionals 醫護人員填寫的轉介表		

YDA Office use only 只供 YDA 內部使用	
Total score 總分	
Result 審核結果	Approved 接納 / Not approved 未能批准
Approved model 批核型號	
Approved quantity 批核數量	
Approval due date 獲批期限	
Approved by 審批同事	
Approval date 批核日期	
First batch of CGM e-coupon redemption date 首次領取 CGM 換領券日期	

To be filled out by medical professionals 此部份由醫護人員填寫

Appendix I Referral Form 附件一：轉介表

Name of Applicant 申請人姓名：_____ Age 年齡：_____

✓ Please tick the appropriate box 請剔選適當的方格

1. Is the applicant currently participating in Hospital Authority's CGM programme?
   申請人現時有否參加醫院管理局轄下連續式血糖監測服務計劃？

☐ **Yes,** reasons (please tick all that apply) 有，原因為（請提供所有合適原因）	
☐ Applicant aged 8 or below 8 歲或以下糖尿病患者	☐ Applicant diagnosed in the past 12 months 12 個月內新確診
☐ Inability to recognise, or communicate about symptoms 無法識別或說出症狀	☐ Applicant is a current insulin pump user 胰島素泵使用者
☐ Applicant experiences recurrent or unaware of hypoglycaemia 重覆出現或不自覺低血糖	☐ HbA1c 7-8% 糖化血紅素為 7-8%
☐ HbA1c 8% and above 糖化血紅素為 8%以上	
☐ **No,** the applicant does not fit into any of the above criteria 否，申請人不符合上述標準	

2. Do you recommend the applicant to join Youth Diabetes Action "CGM Little Rainbow" programme?
   你是否推薦申請人參加兒童糖尿協會的「CGM 小彩虹」計劃？

☐ **Yes,** and I recommend the applicant to use the one of the following brands 是，並建議申請人使用		
☐ Dexcom CGM	☐ FreeStyle Libre	☐ Medtronic CGM
☐ No, I will not recommend 否，我不推薦申請人參加		

3. Supplementary Information (if any) 補充資料（如有）

☐ Applicant is diagnosed **Type II diabetes** and I recommend him/her to join the "CGM Little Rainbow" programme for ____ months
申請人為二**型糖尿病**患者，我推薦申請人參加為期_____個月的「CGM 小彩虹」計劃

_____

_____

Signature of medical professional
醫護人員簽署：_____ Hospital 醫院：_____

Name 姓名：_____ Date 日期：_____