Charitable Financial Assistance Request and Declaration

The Braemar Charitable Trust (BCT) will consider providing financial assistance for elective health procedures where:

1. A patient has been referred as being eligible for financial assistance and the surgeon and anaesthetist agree to waive their fees **and** the patient referral meets the 'Braemar Charitable Trust Criteria and Conditions for Financial Assistance'. BCT will pay the operative and in hospital costs of the procedure which must be performed at Braemar Hospital;
2. An uninsured person has an unexpected return to theatre, BCT will pay the theatre costs of the return but not the surgeons or anaesthetists fees (if any);
3. An uninsured person or ACC patient, who has been a patient of Braemar Hospital is unexpectedly required to be re-admitted to Braemar Hospital as a consequence of the previous admission. BCT will pay the costs of that re-admission, but not the surgeons or anaesthetists fees (if any).

Eligibility for financial assistance will be determined by BCT and is subject to funds being available as determined by BCT prior to the start of each financial year. All patient referrals for financial assistance, must provide all of the requested information in this form.

Please Note: The referrer **must:**

- Provide a covering letter stating why the patient should be considered for financial assistance
- Complete all parts of this form, sign and return the completed form and covering letter to the Trust Manager, Braemar Charitable Trust email: paulab@braemartrust.co.nz or by post to Braemar Charitable Trust, PO Box 972, Waikato Mail Centre 3240.
- All information provided is collected and used in accordance with the Privacy Act 2020, Health Information Privacy Code 2020 and the "Braemar Charitable Trust Privacy Statement" as set out at in this referral form

Approval must be obtained prior to any procedure being performed.

GP/Referrer to Complete: Patient Details:

Family Name:	
First Name:	
Patient Address:	
Patient Date of Birth:	
Patient NHI:	
Patient Phone Number (mobile and landline):	**Home:** **Work:** **Mobile:**
Patient Email Address:	

GP/Referrer to Complete: Dentist/Referrer Details:

GP Name:	
GP Clinic/Practice Name:	
GP Clinic/Practice Phone number:	
GP Clinic/Practice email address:	
Patient Condition and Proposed procedure:	
Any special Considerations (Equipment, special care etc):	

Braemar Charitable Trust Criteria and Conditions for Financial Assistance

GP/Referrer to Complete: Please confirm and verify that your patient meets **all** of the following criteria and conditions for financial assistance:

Does your patient:	
Live within the Waikato DHB Region?	Yes/No
Have Medical Insurance?	Yes/No
Have ACC cover (including either elective surgery or treatment injury provisions)?	Yes/No

Have the financial means to pay (i.e. is the patient asset or cash rich) or have access to private funds that would help pay for the procedure? *There may be cases where it is difficult to decide if your patient has the financial means, or you may have insufficient information. Please indicate on this form if you would like us to contact you. We will get in touch and discuss this referral with you*	Yes/No
Have the means and is willing to contribute some of the costs of their procedure.	Yes/No If you answered yes, how much $
Have any chance of having their procedure performed at a public hospital within a reasonable timeframe?	Yes/No

I have completed all sections of the application form and provided a covering letter stating why my patient should be considered for charitable support.

Signed (GP/Referrer): **Date:**

Application for Financial Assistance for a surgical procedure at Braemar Hospital Limited (Patient to complete):

As a Charitable Trust, we support people in clinical need who have no or limited financial means. Funding for your treatment is provided through Surgeons and Anaesthetists donating their time and services, through organisations making generous charitable donations and from the charitable funds held by BCT. Help can be provided in completing this form by contacting Paula Baker, Trust Manager at paulab@braemartrust.co.nz

Please note, the information you provide will not be given to any third party.

Patient to Complete:

1. Do you have a Community Services Card? If yes, Card Number:	Yes/No
2. Do you receive a WINZ benefit (excluding pension)? If yes, state type and number:	Yes/No
3. Do you have any dependents? If yes, how many Children do you have: How many other dependants do you have:	Yes/No
4. Are you in paid employment? If yes, how many hours a week	Yes/No
5. What is your occupation?	
6. Is one member of your household a New Zealand Citizen or permanent resident?	Yes/No
7. Do you have the financial means to pay or have access to private funds that would help pay for your procedure?	Yes/No
8. Do you have the means and are willing to contribute some of the cost of your procedure? If so, how much are you able to contribute?	Yes/No If you answered yes, how much $

Patient Declaration (Patient to Complete):

I (**Patient to print full name**)

Declare that:

- I have little chance of having my procedure performed at a public hospital within a reasonable timeframe and my condition is impacting on my quality of life
- I do not have medical insurance nor access to private funds that will help pay for my procedure
- ACC will not cover payment for any part of my treatment (including either elective surgery or treatment injury provisions)
- I have NO funds available nor the financial means to pay for private treatment as outlined in the completed "Application for Charitable Financial Assistance"

I understand that charitable support for my procedure is being provided by the Braemar Charitable Trust, who support people in clinical need who have no or limited financial means.

Signed (Patient): **Date:**

Braemar Charitable Trust ("BCT") Privacy Statement

1. This Privacy Statement explains how BCT uses information you give to us, and the way we protect your privacy under the Privacy Act 2020 and the Health Information Privacy Code 2020.

Security

2. Protecting your personal information is of the utmost importance to us. BCT have security measures in place to protect the loss and alteration of information under our control.

Personal information

3. If it is practical to do so, we will collect your information directly from you. This may take place when you complete the "Charitable Financial Assistance Request and Declaration" paperwork for BCT, through your Surgeon, General Practitioner or Dentist.
4. We do not collect personal information unless you choose to give it to us.
5. Information provided will be held by BCT.

Use and disclosure

6. We only use the personal information that you provide to us on this form for the purposes for which you supplied it. We do not share your personal information externally unless this is necessary for the purpose for which you gave us the information (for instance to another treating service or hospital) or sharing is required by law.
7. We cannot use your personal information for direct marketing purposes unless you provide authorisation.

Your rights and choices

8. We are happy to provide you with access to any personal information that we hold about you. If it is incorrect, please ask us to amend it. To ask for access, correction or to ask for explanations of what we do with your information, please contact Paula Baker at: paulab@braemartrust.co.nz or by post to Braemar Charitable Trust, PO Box 972, Waikato Mail Centre 3240.

Financial Assistance Request Checklist:

Prior to submitting the request for financial assistance, GP's/Referrers please check that you have provided all of the information outlined below:

- Have all sections of the request form been completed and signed by the GP/Referrer and the Patient?
- Has a covering letter been provided from the GP/Referrer stating why the patient should be considered for financial assistance?
- Has the patient completed and signed the "Application for Charitable Financial Assistance"?

For Office Use Only

To the Braemar Charitable Trust Trustees:

Braemar Hospital have estimated the in-hospital costs of this procedure (and therefore the financial assistance being sought from the Braemar Charitable Trust) to be:

This request for financial assistance meets all criteria and conditions for financial assistance and your approval of this request is recommended:

Signed (Braemar Charitable Trust Manager):

Date:

To Braemar Hospital CEO/Finance Manager:

This application has been approved/declined by the Braemar Charitable Trust