

Community Surgery Request and Declaration

The Braemar Charitable Trust (BCT) will consider funding elective health procedures under its Community Surgery Programme where a patient:

1. Meets the Braemar Charitable Trust Community Surgery Programme criteria. BCT will pay the operative and in-hospital costs of the procedure when performed at Braemar Hospital;
2. Has been declined or has little chance of having their procedure performed at a public hospital within a reasonable timeframe and the condition is significantly impacting on quality of life;
3. Does not have medical insurance nor access to private funds that will help pay for their procedure;
4. Does not have ACC cover for any part of my treatment (including either elective surgery or treatment injury provisions)
5. Does not have the financial means to pay for private treatment.

The decision whether a patient is eligible to receive a free elective procedure under the Braemar Charitable Trust Community Surgery Programme, will be determined by BCT and is subject to available funds and surgeon availability. Where procedures are in high demand, BCT will prioritise complex cases where patients face multiple barriers to accessing treatment.

Referrals can be made by Specialists, General Practitioners, Dentists and Nurse Practitioners and must include sufficiently detailed medical notes so an assessment can be made prior to approval.

Please note: The referrer **must:**

- Provide a covering letter stating why the patient should be considered for assistance through the Community Surgery Programme
- Complete all parts of this form, sign and return the completed form and covering letter to the Trust Manager, Braemar Charitable Trust, email: admin@braemartrust.co.nz
- 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.

Referrer to Complete: Patient Details:

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

Referrer to Complete: Referrer Details:

Referrer Name:	
Referrer Clinic/Practice Name:	
Referrer Clinic/Practice Phone number:	
Clinic/Practice email address:	
Patient condition and proposed procedure: (Please include a photo illustrating any external skin lesions or conditions requiring surgical intervention)	
Any special considerations (equipment, special care etc):	

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 Midlands Region?	Yes/No
Have medical insurance?	Yes/No
Have ACC cover (including either elective surgery or treatment injury provisions)?	Yes/No
Has the patient been declined, or has little chance of having their procedure performed at a public hospital within a reasonable timeframe?	Yes/No
Have the financial means to pay for the full procedure (i.e. is the patient asset or cash rich) or have access to private funds that would help pay for the procedure?	Yes/No
Have some financial means and is willing to contribute to some of the costs of their procedure the Trust faces e.g. for consumables, drugs or surgical items	Yes/No If you answered yes, how much \$

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 (Referrer):

Date:

Application for Financial Assistance for a Surgical Procedure at Braemar Hospital Limited

BCT supports people in clinical need who have no or limited financial means. Funding for your treatment is provided by Surgeons and Anaesthetists donating their time and services, through organisations making generous charitable donations and from the charitable funds held by BCT. As BCT must cover the cost of consumables, drugs, and surgical items, we do ask that patients consider making a donation to help us - if you can do that, these funds can be used to assist another community surgery recipient. Help can be provided in completing this form or contacting Paula Baker, Trust Manager, at admin@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 If you have a partner, are they in paid employment? If yes, how many hours a week	Yes/No
5. What is your occupation? If you have a partner, what is their 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 for your full procedure or do you have access to private funds that would pay for your full procedure?	Yes/No
8. However, do you have some means and would be willing to contribute some of the cost of your procedure? If so, please let us know how much you would like to donate, and we will facilitate a donation.	Yes/No Dollar amount:

Patient Declaration (Patient to Complete):

I _____ (Patient to print full name)

Declare that:

- I have been declined or have little chance of having my procedure performed at a public hospital within a reasonable timeframe and that my condition is impacting on my quality of life
- I do not have medical insurance
- 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 Financial Assistance".

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

Signed (Patient):

Date:

Financial Assistance Request Checklist:

Prior to submitting the request for financial assistance, 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 Referrer and the patient? Including a photo illustrating any external skin lesions or conditions requiring surgical intervention?
- ☐ Has a covering letter been provided from the Referrer stating why the patient should be considered for financial assistance?
- ☐ Has the patient completed and signed the "Application for Financial Assistance"?

Approval must be obtained prior to any procedure being performed.

**Thank you. Please scan and email your form to Braemar Charitable Trust at admin@braemartrust.co.nz
We will be in touch soon.**

Braemar Charitable Trust ("BCT") Privacy Statement

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

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

Personal information

- 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, Nurse Practitioner or Dentist.*
- We do not collect personal information unless you choose to give it to us.*
- Information provided will be held by BCT.*

Use and disclosure

- 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.*
- We cannot use your personal information for direct marketing purposes unless you provide authorisation.*

Your rights and choices

- 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: admin@braemartrust.co.nz*