

THE SKIPTON FUND

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GUIDANCE NOTES FOR APPLICATION FORM FOR FIRST STAGE EX GRATIA PAYMENT OF £20,000.

TO THE APPLICANT

Thank you for registering with the Skipton Fund. Please read these notes carefully before completing the form. Please also show these notes to the medical professional who you ask to complete the rest of the form after you have completed and signed Part 1.

HOW TO COMPLETE THE FORM

Page 2 of the application form must be completed by the person making the claim. In nearly all cases this will be you, the infected person; if such a claimant is unable to complete the first two pages of the form, they can be completed by a representative as long as this is made clear on the form.

If the application is for a payment that would have been made by somebody who has died, the form asks for information about the dead person.

All the rest of the form after page 2 must be completed by a medical professional, to whom you should give the form after you have completed and signed the first two pages. You should also give these guidance notes to that medical professional.

Generally this medical professional should be the principal clinician treating you; this will probably be a clinician treating Hepatitis C, but in the case of applicants with bleeding disorders it might be a haematologist.

If you cannot give this form to such a clinician to complete, you should take it to your General Practitioner, again with these guidance notes.

If you yourself have any records of how you were infected, please give them to the medical professional who will be completing the remainder of the form.

When the medical professional has completed the form, he or she should send it to the Skipton Fund where it will be processed. Provided that the information supplied confirms your eligibility for a payment, this will be made as soon as possible after the receipt of the form by the Skipton Fund.

If you have any difficulties in understanding what you should do with this application form, please telephone the Skipton Fund Helpline on (0207 808 1160). In case your call has to be recorded, please be ready to leave a telephone number to which it will be possible to return your call.

TO APPLY FOR SECOND STAGE EX GRATIA PAYMENT OF £25,000

The Skipton Fund will be processing applications for the first stage ex gratia payments as a matter of priority. You will be able to apply for the second stage ex gratia payment at any time in the future. If you believe that you are eligible for this payment, please ask the Skipton Fund for the relevant application form.

PART 1A - TO BE COMPLETED BY OR ON BEHALF OF THE APPLICANT

Please complete the following in block capitals:

If you are completing this form on behalf of somebody who is unable to do it himself or herself, please supply the following information about that person. If you are claiming as the bereaved partner, parent or dependant of somebody who died after 29 August 2003, please supply the following information about the deceased.

Title (Mr/Ms/Mrs/other) Surname

First name Middle name/s

Address

 Post Code

What is or was your relationship to this person?

If the infected person has died, please supply the SKIPTON FUND with a copy of the death certificate.

PART 1B - TO BE COMPLETED BY THE APPLICANT

DATA PROTECTION

Your personal information will only be used by the Skipton Fund on behalf of the Department of Health (England), acting for and on behalf of the Secretary of State for Health, the Scottish Ministers, the National Assembly for Wales and the Department of Health, Social Services and Public Safety (Northern Ireland) (together “the UK health administrations”) to check your eligibility for a payment and to administer your application. In the event of a dispute as to your eligibility for payment, your information may be disclosed to the Department of Health (acting for and on behalf of the UK health administrations) Appeals Panel. Your information will otherwise be held in the strictest confidence and will not be shared with any other organisation.

By submitting this form to a medical professional, you consent to your medical details requested in Parts 2 being supplied to the Skipton Fund and the Department of Health (acting for and on behalf of the UK health administrations) for the purpose of administering your application. If your application is ultimately deemed to be ineligible for the ex gratia payment your information will be deleted. If you have any questions regarding the use of your information, please contact 0207 808 1160.

Do you consent to the medical details requested in Parts 2, 3 and 4 being supplied to the Skipton Fund? *Delete as appropriate
YES/NO*

If you have any records of how you (or the deceased person) were infected, please give them to the medical professional who will be completing the remainder of the form.

By signing this form I declare that the information I have given on the form is correct and complete and that I have not previously claimed for the first stage ex-gratia payment of £20,000 from the Skipton Fund. I understand that if I knowingly provide false information that I may be liable for prosecution and civil recovery proceedings. I consent to the disclosure of the information from this form to and by the Skipton Fund and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution fund.

I wish to apply for a £20,000 ex gratia payment.

Signature of Applicant Date

FOR SCOTTISH APPLICANTS ONLY:

By signing this form I confirm that this claim meets the further criteria for claims emanating from Scotland as set out in section 2 of the Guidance Notes entitled “THE SKIPTON FUND - What it is and how it works”.

TO BE COMPLETED BY YOUR HOSPITAL DOCTOR OR GENERAL PRACTITIONER

NOTES TO THE MEDICAL PROFESSIONALS COMPLETING THIS FORM.

Thank you for your help with this application.

In most cases this form will concern a patient who is known to you who has been infected with Hepatitis C.

The purposes of this form are

- to confirm that the patient has been infected
- to confirm that the infection most probably arose through NHS treatment

If there are questions in this form relating to your patient that you cannot answer, please consult such other medical professionals as have treated your patient who would be able to provide such answers.

In a few cases this form will concern a patient who had been infected with Hepatitis C but who died after 29 August 2003. In such a case all the questions you are requested to answer refer to the deceased person.

In a few cases this form will concern a patient who has been indirectly infected (e.g. by accidental needle stick) by somebody who is (or was) himself or herself infected through NHS treatment. In such a case please answer only parts 2A, 2B, 4B and 5.

Please return this form, when completed, to the Skipton Fund in the freepost envelope supplied.

Skipton Fund Limited
Freepost NAT18555
London
SW1H 0BR

PART 2A - TO CONFIRM THE APPLICANT'S ELIGIBILITY FOR PAYMENT

Has an HCV antibody test ever been positive? YES/NO*

Is the applicant currently PCR positive? YES/NO*

If the applicant is currently PCR negative, is this as a result of past or ongoing interferon-based treatment? YES/NO*

If the applicant is PCR negative is there radiological or pathological evidence that they were chronically infected after the acute phase (ie the first six months) of the illness had passed?
(Relevant radiological or pathological evidence would include chronic-phase raised liver-function tests, previous consideration for treatment, liver histology or radiography, other symptoms of chronic Hepatitis C.) YES/NO*

PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING THE ABOVE ANSWERS

PART 2B - TO CONFIRM WHETHER INFECTION AROSE INDIRECTLY

In your opinion, is it probable the applicant was infected as a result of transmission of the virus from another person who had himself/herself been infected through treatment with blood, blood products or tissue? YES/NO*

If YES did transmission occur as a consequence of

- sexual intercourse? YES/NO*
- accidental needle stick? YES/NO*
- mother-to-baby transmission? YES/NO*
- other (please specify)?

Please provide details of which genotype the applicant is infected with

If any of the answers in part 2B is 'YES', please ignore the rest of parts 2, 3 & 4A and go to part 4B.

PART 2C - TO CONFIRM THAT A DECEASED PERSON WOULD HAVE BEEN ELIGIBLE FOR PAYMENT

Did the deceased person ever test positive for HCV antibodies? YES/NO*

Was the deceased person PCR positive at the time of death? YES/NO*

If either of these answers is 'yes', please complete the remainder of this form in respect of the deceased person.

If at the time of death the applicant was PCR negative was this as a result of interferon based treatment? YES/NO*

If the infected person has or had haemophilia or any other inherited or acquired bleeding disorder, please go to Part 3, but ignore part 4.

*Delete as appropriate

PART 3 - TO BE COMPLETED ONLY IN RESPECT OF INFECTED PEOPLE, WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS

i) Please confirm that the infected person has or is a carrier of an inherited or acquired bleeding disorder YES/NO*
 (such as haemophilia or von Willebrand's disorder)

ii) Were any of the following used to treat the infected person before 1 September 1991?

(please tick where appropriate)

- Factor VIII concentrate
- Factor IX concentrate
- Cryoprecipitate
- FEIBA
- Plasma/FFP
- Whole blood or components (components include platelets, red cells, neutrofiles etc)

Did treatment include repeated doses? YES/NO*

Other coagulation factor concentrate

If so which?

iii) In which NHS hospital(s) did the infected person receive the products listed before 1 September 1991?

iv) If none of the products listed above was used to treat the infected person before 1 September 1991, do you believe that the infected person's Hepatitis C infection was caused through NHS treatment received before that date? YES/NO*

PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING THE ABOVE ANSWERS

If part 3 has been completed ignore part 4 and go straight to part 5.

*Delete as appropriate

PART 4A - TO CONFIRM THAT INFECTION MOST PROBABLY AROSE THROUGH NHS TREATMENT . (NOT TO BE COMPLETED IN RESPECT OF PEOPLE WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS)

i) When where and how is it believed that infection occurred?

When? (date)

Where? (in what NHS hospital or other facility)

How? (during surgical procedures, A&E treatment, etc) Please specify.

ii) Do any records exist of this possible occasion of infection?

If YES, please specify and enclose a copy of the relevant records

iii) If the date of infection cannot be proved, do you believe infection occurred before 1 September 1991?

YES/NO*

iv) Were any of the following used to treat the applicant before 1 September 1991?

(please tick where appropriate)

Intravenous immunoglobulin	<input type="checkbox"/>	Plasma/FFP	<input type="checkbox"/>
Albumin	<input type="checkbox"/>	DEFIX	<input type="checkbox"/>
Bone marrow	<input type="checkbox"/>	Whole blood or components	<input type="checkbox"/>

(components include platelets, red cells, neutrofilis etc)

If so, for what purpose, and did the treatment involve repeated doses?

v) Does any evidence exist of any other possible source of infection

(e.g. treatment with other blood products or tissue, etc)?

YES/NO*

If YES, please specify

*Delete as appropriate

PART 4B - OTHER POSSIBLE SOURCES OF INFECTION (NOT TO BE COMPLETED IN RESPECT OF PEOPLE WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS)

Based on evidence or your experience, has the infected person been treated for intravenous drug use?

YES/NO*

Has the infected person ever received hospital treatment outside the UK?
If YES, what treatment and where?

YES/NO*

Is there any other evidence that might affect the eligibility of the infected person for payment?
If YES, please specify?

YES/NO*

In your view is it probable that the infected person's HCV infection was acquired in consequence of NHS treatment received before 1 September 1991?

YES/NO*

*Delete as appropriate

PART 5 - TO CONFIRM THE AUTHORITY OF RESPONDENT(S)

How long have you known the person in respect of whom you have completed this form?

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp

Clinician's
GMC number

How long have you known the person in respect of whom you have completed this form?

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp

Clinician's
GMC number

How long have you known the person in respect of whom you have completed this form?

years months

Name of Clinician

Department

Hospital

Address

Post Code

Signature of Clinician

Hospital Stamp

Clinician's
GMC number

How long have you known the person in respect of whom you have completed this form?

years months

Name of GP (if relevant)

Surgery

Address

Post Code

Signature of GP

Surgery Stamp &

GMC number

By signing this form I confirm that the information contained within parts 2 – 5 of the form is true to the best of my knowledge and belief and that if I knowingly authorise false information this may result in disciplinary action and I may be liable to prosecution. I consent to the disclosure of information from this form to and by the Skipton Fund and the NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and for the investigation, prevention, detection and prosecution of fraud.

Please return the completed form to the Skipton Fund in the freepost envelope supplied

Thank you very much for your help in completing this form