

# 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 in respect of somebody who has died, the form asks for information about the deceased 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 the guidance notes to that medical professional.**

Generally this medical professional should be the principal clinician treating you or who had treated the deceased; this will probably be a clinician treating hepatitis C, but in the case of applicants with bleeding disorders, or in respect of someone deceased who had a bleeding disorder, it might be a haematologist.

If you cannot give this form to such a clinician to complete, you should take it to your or the deceased person's General Practitioner, again with the guidance notes.

If you yourself have any records of how you or the deceased 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 along with supporting documents where it will be processed. Provided that the information supplied confirms 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**

Before applying for the second stage payment a successful first stage application has to have been paid to confirm eligibility. If, after receiving the first payment, 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, OR IN RESPECT OF SOMEONE WHO IS DECEASED**

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 in respect of somebody who is deceased, 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 and you did not supply the Skipton Fund with a copy of the death certificate during registration then please attach a copy to this form.

**PART 1B - TO BE COMPLETED BY THE APPLICANT OR THE PERSON MAKING THE APPLICATION ON BEHALF OF THE ESTATE IF THE APPLICANT IS DECEASED**

**DATA PROTECTION – For living applicants only**

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, 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 (England) 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 - 4 being supplied to the Skipton Fund and the Department of Health (England) 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 regarding your hepatitis C status (or that of the deceased person), please give them to the medical professional who will be completing the remainder of the form.

**For all applicants**

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 on behalf of myself or, if applying in respect of a deceased person, that the estate has not previously applied 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 NHS Counter Fraud and Security Management Service for the purpose of verification of this claim and the investigation, prevention, detection and prosecution of fraud.

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

**Signature of applicant or the person making the application on behalf of the estate if the applicant is deceased**

**Date**

**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 chronically infected
- to confirm that the infection most probably arose through treatment with NHS blood or blood products

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 some cases this form will concern a patient who had been infected with hepatitis C but who has since died. In such a case all the questions you are requested to answer refer to the deceased person.

In some 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 (or 2C), 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 OBR

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

Has an HCV antibody test ever been positive?	YES/NO*
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Is the applicant currently PCR/RNA positive?	YES/NO*
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If the applicant is currently PCR/RNA negative, is this as a result of past or ongoing interferon-based treatment?	YES/NO*
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<p>If the applicant is PCR/RNA 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.)</p>	YES/NO*
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PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING ALL OF THE ANSWERS IN PART 2A

**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*
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<p>If YES did transmission occur as a consequence of</p> <ul style="list-style-type: none"> <li>• sexual intercourse?</li> <li>• accidental needle stick?</li> <li>• mother-to-baby transmission?</li> <li>• other (please specify)?</li> </ul>	<p>YES/NO*</p> <p>YES/NO*</p> <p>YES/NO*</p>
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Please provide details and a copy of test result to confirm which genotype the applicant is/was infected with

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

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

Did the deceased person ever test positive for HCV antibodies?	YES/NO*
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Was the deceased person PCR/RNA positive at the time of death?	YES/NO*
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If at the time of death the applicant was PCR/RNA negative was this as a result of interferon-based treatment?	YES/NO*
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If the deceased person died before tests for hepatitis C were available, was a diagnosis of non-A, non-B hepatitis associated with receipt of a blood transfusion, blood component or blood products made?	YES/NO*
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PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING ALL OF THE ANSWERS IN PART 2C

**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/had or is/was a carrier of an inherited or acquired bleeding disorder (such as haemophilia or von Willebrand's disorder) YES/NO\*

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 treatment with NHS blood or blood products 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 4A and go straight to part 4B.

\*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

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

YES/NO\*

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

YES/NO\*

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

YES/NO\*

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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?  
If NO, please give your reasons?

YES/NO\*

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\*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**