**M****alaysian Skin Foundation Patient Assistance Programme Application Form**

1. Malaysian Skin Foundation Patient Assistance Programme (MSF PAP) aims to improve treatment access in patients with chronic skin diseases by providing financial assistance in their therapy.
2. This application is only open to **Malaysians** and must be completed by a qualified dermatologist registered in National Specialist Registry
3. Financial assistance for therapy will depend on the applicant’s socioeconomic status and is **capped at a maximum of RM1000** **per month.** This subsidy is provided for **6 months** and is subject to renewal for another 6 months pending recommendation by the treating dermatologist. Submission of the application does not guarantee the provision of subsidy and is subject to approval by the Board of Trustees.
4. Only application forms accompanied with the following supporting documents (where applicable) will be considered:
   1. Copy of NRIC
   2. Letter from employer certifying salary or salary slips (patient & family members within the same household who are working)
   3. Latest Employees’ Provident Fund (EPF) statements (patient & family members within the same household who are working)
   4. Latest BE form (for the self-employed)
   5. Latest utility bills (water, electricity, telephone, internet)
   6. Any other supporting documents that are deemed helpful for MSF to understand the family’s situation
5. If the drug is used for an off-label indication, the dermatologist is first required to apply for approval from the MoH by completing *Borang BPF/103-KPK01S*. The MoH approval letter should then be submitted together with this application form.
6. The dermatologist is required to email all the documents to: [pap@malaysianskinfoundation.org](mailto:pap@malaysianskinfoundation.org)
7. Applications will **not** be processed if the form and/or its supporting documents are not complete.

**Section A: Patient Information**

|  |  |
| --- | --- |
| Patient’s Name |  |
| NRIC |  |
| Age |  |
| Sex | Male  Female |
| Mobile Number |  |
| Email Address |  |
| Marital Status | Single  Married  Separated  Divorce  Widowed |
| Number of Children |  |
| Home Address |  |
| Dwelling Type |  |
| Rental Status | Rented  Owned |
| Diagnosis |  |
| Type of Treatment Required | Adalimumab  Omalizumab  Infliximab  Brodalumab  Ixekizumab  Secukinumab  Guselkumab  Risankizumab Dupilumab  Upadacitinib  Baricitinib  Others (Please Specify): |

**Section B: Family Income Information**

1. Please provide the detailed information of self, nuclear family members living in the same household or living separately (if any) in tables below:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Name | Age | Sex | Relationship | Occupation | Company/  School | Monthly Income /Contribution to patient (RM) |
| 1 |  |  |  |  |  |  |  |
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |
| 8 |  |  |  |  |  |  |  |
| 9 |  |  |  |  |  |  |  |
| 10 |  |  |  |  |  |  |  |
| 11 |  |  |  |  |  |  |  |
| 12 |  |  |  |  |  |  |  |
| 13 |  |  |  |  |  |  |  |
| 14 |  |  |  |  |  |  |  |
| 15 |  |  |  |  |  |  |  |
| 16 |  |  |  |  |  |  |  |
| 17 |  |  |  |  |  |  |  |
| 18 |  |  |  |  |  |  |  |
| Total number of Household members: | | | | | | **TOTAL (A):** |  |

1. Other Sources of Income (e.g. welfare assistance, SOCSO pay-outs, rental income etc.): **(B)** = **RM**
2. **Grand total monthly income**: **(C) =** (**A) + (B) = RM**

**Section C: Monthly Household Expenses**

|  |  |
| --- | --- |
| **Expenses** | **Amount (RM)** |
| 1. Rent / House Loan |  |
| 1. Electricity Bill |  |
| 1. Water Bill |  |
| 1. Telephone Bill |  |
| 1. Internet |  |
| 1. Food |  |
| 1. Auto Loan |  |
| 1. Petrol |  |
| 1. Transportation Expenses |  |
| 1. Insurance |  |
| 1. Medical Expenses |  |
| 1. Children Pocket Money |  |
| 1. Contribution to Parents |  |
| 1. Others, Please specify: |  |
| **TOTAL** |  |

**Section D: Declaration**

I,       (NRIC:      ), hereby declare that all of the information provided in this application form is true and accurate to the best of my knowledge. I understand that the information is used to assess my/family’s eligibility for Malaysia Skin Foundation Patient Assistance Programme (MSF PAP) and the submission of the application does not guarantee the provision of MSF PAP. I also understand that my application might not be processed if I do not cooperate in supplying any additional requested information when deemed necessary. I agree to be interviewed by social worker for the purpose of MSF PAP application. The Committee reserves the right to use and disclose all information contained herein to a third party if there is a need.

Signature:

……………………………………………………..

Relationship to the patient (if applicable):      

Date:

**Section E: Verification By Dermatologist In-charge**

|  |  |
| --- | --- |
| Patient’s Name |  |
| NRIC |  |
| Diagnosis |  |
| Type of treatment required |  |
| Dosage & Regime |  |
| Treatment Duration (Max. 6 Months) |  |
| Cost of treatment | RM: |
| Any other source of assistance/Patient Assistance Programme (e.g. AXIOS) | Yes  No  If yes, please specify: |

Signature:

……………………………………………………..

Dermatologist Name:

Clinic/Hospital Address: