Cynllun Cynorthwyo Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

FORM D

APPLICATION FOR A HIV PAYMENT WHERE THE INFECTED PERSON IS DECEASED

SECTION 1 (A) DATA PROTECTION AND APPLICANT'S DECLARATION

✓ Please tick to confirm

☐ **I understand** that data I provide may be shared with NHS service providers and Counter Fraud Services to ensure accurate and timely payment and for the purposes or prevention, detection and investigation of crime.

DECLARATION BY APPLICANT

I agree that the information I give on this form is complete and correct.

I agree to repay any money I receive to which it is found that I am no longer entitled.

I understand if I knowingly give wrong or incomplete information I may be prosecuted.

I confirm that I am the sole Executor of the estate of the deceased person this application relates to, or I am making this application on behalf of all the appointed Executors of the estate.

I agree to NHS Wales obtaining any data held on the deceased person this applications relates to from the Skipton Fund or the Caxton Foundation for the purposes of providing me with financial support.

I understand that NHS Wales may require to access data held on the deceased person by other public bodies and/or make any additional enquiries with other public bodies that may be necessary in order to reach a decision regarding this application.

Signature of Applicant		Date	

HOW WE USE YOUR INFORMATION

The personal information that you provide on this form will only be used by Velindre NHS Trust for the purposes of checking your eligibility for a payment and to administer your application. By submitting this form to a medical professional, you consent to the deceased person's medical details requested in Sections 1 to 6 inclusive being supplied to Velindre NHS Trust for the purpose of administering your application.

In the event of a dispute as to your eligibility for payment, your information may be disclosed to the Appeals Panel. If your application is deemed to be ineligible, Velindre NHS Trust may keep your application form on file so that we have a full historical record in the event that you lodge an appeal or if you reapply for a payment at a later stage, in any event information we hold about you will be held for the purpose we collected it and kept for at least six years.

Your information and the deceased person's will be held in the strictest confidence and will be kept securely, in accordance with the Data Protection Act 1998, and will not be shared with any other organisation. Velindre NHS Trust are a Data Controller under the Act in respect of the personal information which we collect about you. We have notified the Information Commissioner of our data processing activities and our registration number is Z5021900.

If you have any questions regarding the use of your information, or have any concerns with how your information is being processed, or wish to obtain a copy of information held by us about you, please contact us by writing to Velindre Cancer Centre, Velindre Road, Whitchurch, Cardiff, CF14 2TL

SECTION 1 (B) APPLICATION DETAILS

The person completing this form must be an Executor of the deceased person's estate.

Please provide your details here:

Title		First Name	
Middle Name(s)		Surname	
Address			
		Post Code	
Main Telephone		Mobile Telephone	

SECTION 1 (C) DECEASED PERSON'S DETAILS

Please provide details of the deceased person that the application relates to:

Title		First Name	
Middle Name(s)		Surname	
Previous Names			
Address (their Main residence at the date of death)			
		Post Code	
Date of Birth		Date of Death	

SECTION 1 (D) DECEASED PERSON'S ESTATE

Did the deceased person leave a will? Yes ☐ No ☐

Had the grant of representation been requested for the deceased person's estate? Yes ☐ No ☐

If 'Yes', has the grant of representation been granted? Yes ☐ No ☐

Is there anyone else who might apply to the scheme for a payment in respect of the deceased person? Yes ☐ No ☐

If 'Yes', please provide their details:

Title ☐ First Name ☐

Middle Name(s) ☐ Surname ☐

Address ☐

☐

☐ Post Code ☐

Date of Birth ☐ Date of Death ☐

What was their relationship to the deceased person? ☐

Why do you feel this person might apply to the scheme?

☐

SECTION 1 (E) ADDITIONAL APPLICATION DETAILS

Do you believe the deceased person was infected with HIV as a result of treatment they received themselves with NHS blood, tissue,
or blood products? Yes ☐ No ☐

If 'Yes', please provide as much information as you can on how you believe the infection occurred

Alternatively, do you believe they were infected with HIV as a result of the virus being transmitted from someone else, who themselves were infected as a result of treatment with NHS blood, tissue, or blood products? Yes ☐ No ☐

If 'Yes', please provide further details below:

Firstly, how do you believe the infection occurred?

Secondly, who do you believe the deceased person received the infection from?

Title | First Name

Middle Name(s) | Surname

Address

Post Code

What was the deceased person's relationship to this person?	

SECTION 1 (F) ADDITIONAL INFORMATION

If you have any additional information you would like to provide, please add it here:

Once you have completed all parts of Section 1, please pass the form to a medical professional to complete.

The medical professional will complete the remainder of the form and return it directly to the Wales Infected Blood Support Scheme on your behalf.

THE FOLLOWING SECTIONS MUST BE COMPLETED BY A MEICAL PROFESIONAL

GUIDANCE NOTES FOR MEDICAL PROFESSIONALS

Thank you for your help with this application. In most cases this form will concern a deceased person who is known to you and who had been infected with HIV.

Sections 2-5 of this form should be completed in all cases. The purpose of these sections is:

- To confirm that the deceased person had been infected with HIV

  AND

- To confirm that the infection most probably arose through treatment with NHS blood, tissue or blood products

If there are questions in this form relating to the deceased person that you cannot answer, please consult other medical professionals who have treated the deceased person and who would be able to provide the information.

In some cases this form will concern a deceased person who had been indirectly infected by somebody who is (or was) infected themselves through NHS treatment.

When complete, please return this form along with all relevant documents direct to the following address:

Velindre Cancer Centre
Wales Infected Blood Support Scheme
Velindre Road
Cardiff
CF14 2TL

SECTION 2 (A) | MEDICAL PROFESSIONAL'S DECLARATION

✓ Please tick to confirm

☐ **I understand** that data I provide may be shared with NHS Counter Fraud Services to ensure accurate payment and for the purposes of prevention, detection and investigation of crime.

DECLARATION BY MEDICAL PROFESSIONAL

I agree that the information I give in Sections 2-5 of this form is complete and correct.

I understand that if I knowingly give or endorse wrong or incomplete information this may result in disciplinary action and I may be prosecuted.

Signature of Medical Professional		Date	
Print Name			

SECTION 2(B) DETAILS OF MEDICAL PROFESSIONAL COMPLETING FORM

Registered Medical Practitioner's GMC registration number (if practising in UK)

In what capacity have you completed this form? (e.g. GP, consultant, etc.)

How long had you known the deceased person in respect of whom you have completed this form? Years Months

Your Details

Title First Name

Middle Name(s) Surname

Hospital/Surgery Address

Post Code

Telephone E-Mail Address

If you consulted any other medical professional(s) to help you complete this form, please provide their details here:

SECTION 3 (A) TO CONFIRM THE DECEASED PERSON'S ELIGIBILITY FOR PAYMENT

Are there any records to suggest the deceased person or someone representing their estate had previously applied to another UK scheme (e.g. Skipton Fund) to receive payments with regards to their HIV infection?

Yes ☐ No ☐

If 'Yes', please provide details below.

Had the deceased person tested positive for HIV? Yes ☐ No ☐

If 'Yes', what was the date of first diagnosis? ☐

PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING ALL OF THE ANSWERS IN SECTION 3(A)

SECTION 3 (B) TO CONFIRM WHETHER INFECTION AROSE INDIRECTLY

In your opinion, is it probable the deceased person was infected as a result of transmission of the virus from another person who had themselves been infected through treatment with NHS 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)	Yes ☐	No ☐

PLEASE PROVIDE DETAILS AND A COPY OF TEST RESULTS

If any of the answers in Section 3(B) are 'Yes', please go to Section 5(B)

SECTION 4	TO BE COMPLETED ONLY IN RESPECT OF INFECTED PEOPLE, WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS

Did the deceased person have, or was a carrier of, an inherited or acquired bleeding disorder? (e.g. Haemophilia or Von Willebrand disease) Yes ☐ No ☐

Were any of the following used to treat the deceased person before September 1991?

• Whole blood or components (including platelets, red cells, neutrofils etc.)	Yes	☐	No	☐
• Cryoprecipitate	Yes	☐	No	☐
• Plasma/FFP	Yes	☐	No	☐

Were any of the following used to treat the deceased person before September 1991?

• Factor VIII concentrate	Yes	☐	No	☐
• Factor IX concentrate	Yes	☐	No	☐
• FEIBA	Yes	☐	No	☐
• DEFIX	Yes	☐	No	☐
• Fibrinogen	Yes	☐	No	☐
• Other coagulation factor concentrate	Yes	☐	No	☐

If other coagulation factor concentrate, which?

Did any of the above treatments include repeated doses? Yes ☐ No ☐

Please indicate volumes used for each product.

In which NHS hospital(s) did they receive the products listed before September 1991?

If none of the products listed above was used to treat the deceased person before September 1991, do you think it is probable that their Hepatitis C infection was caused through treatment with NHS blood or blood products received before September 1991? Yes ☐ No ☐

If 'Yes', please provide details

PLEASE PROVIDE A COPY OF MEDICAL RECORDS CONFIRMING THE ANSWERS PROVIDED IN SECTION 4

If Section 4 has been completed and the deceased person's source of infection is likely to have been a blood transfusion(s), rather than blood products, please complete Section 5(A)

Otherwise, if Section 4 has been completed, please go straight to Section 5(B)

SECTION 5 (A) TO CONFIRM THAT INFECTION MOST PROBABLY AROSE THROUGH NHS TREATMENT

On which date is it believed that infection (e.g. via a blood transfusion) occurred?

In what NHS hospital or other facility is it believed infection occurred? (If the deceased had more than one blood transfusion or tissue transplant please list all the hospitals or facilities where they took place)

Please specify under what circumstances is it believed that infection occurred? (e.g. during surgical procedures, A&E treatment, etc.)

Do any records exist of the possible occasion(s) of infection and of any symptoms of infection? Yes ☐ No ☐

If 'Yes', please specify and enclose a copy of the relevant records.

Were any of the following used to treat the deceased person before September 1991?

- Albumin — Yes ☐ No ☐
- Intravenous immunoglobulin — Yes ☐ No ☐
- Plasma/FFP — Yes ☐ No ☐
- Bone marrow — Yes ☐ No ☐
- Whole blood or components (including platelets, red cells, neutrofils etc.) — Yes ☐ No ☐

If so, for what purpose and did the treatment involve repeated doses? (please indicate volumes used for each product)

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

If the date of infection cannot be proved, do you think it is probable that infection occurred before September 1991? Yes ☐ No ☐

If 'Yes', please specify

SECTION 5(B) | OTHER POSSIBLE SOURCES OF INFECTION

Based on evidence or your experience, had the deceased person ever been treated for, or been involved with injecting drug use?
(This could include living with, or being in a sexual relationship with a person who injected drugs)

☐ Yes ☐ No

If 'Yes', please confirm what treatment, where and when?

Has the applicant ever received hospital treatment outside the UK?

Yes ☐ No ☐

If 'Yes', please confirm what treatment, where and when?

Is there any other evidence that might affect the eligibility of the Deceased person for payment?
(e.g. being in a sexual relationship with people in a group with high HIV prevalence, or from countries with high HIV prevalence)

Yes ☐ No ☐

If 'Yes', please specify

In your opinion, is it probable that the deceased person's HIV infection was acquired as a consequence of NHS treatment received before 1991?

Yes ☐ No ☐

If 'No', please give your reasons

Thank you for completing this form. The form and all supporting documents must be sent directly to the Wales Infected Blood Support Scheme at:

Wales Infected Blood Support Scheme
Velindre Cancer Centre
Velindre Road
Whitchurch
Cardiff CF14 2TL