



Cynllun Cynorthwyo Gwaed  
wedi'i haentio Cymru  
Wales Infected Blood  
Support Scheme

## FORM B APPLICATION AND GUIDANCE NOTES APPLICATION FOR A STAGE 1 CHRONIC HEPATITIS C PAYMENT WHERE THE INFECTED PERSON IS DECEASED

### GUIDANCE NOTES FOR APPLICANT

This form allows the Estate of someone who has died to make a claim to the Wales Infected Blood Support Scheme, in cases where the deceased person was not already registered with the scheme, or any other UK Schemes or Legacy Schemes (e.g. Skipton Fund) with regard to chronic Hepatitis C payments, and:

- Were infected by Hepatitis C as a result of treatment they received themselves with NHS blood, tissue, or blood products from a medical establishment in Wales

Or

- Were infected by Hepatitis C as a result of the virus being transmitted from someone else, who themselves was infected by Hepatitis C as a result of treatment they received with NHS blood, tissue, or blood products from a medical establishment in Wales.

**If your circumstances differ to the above, please contact the Wales Infected Blood Support Scheme for guidance. To apply to WIBSS the person would need to have been infected in Wales. Alternatively, to contact the other schemes please see details below:**

England Infected Blood Support Scheme: 0300 330 1294

**Email:** [nhsbsa.eibss@nhs.net](mailto:nhsbsa.eibss@nhs.net)

Scottish Infected Blood Support Scheme: 0131 2756754

**Email:** [nss.sibss@nhs.net](mailto:nss.sibss@nhs.net)

Northern Ireland Infected Blood Support Scheme: 028 9536 3817

**Email:** [bsi.ibss@hscni.net](mailto:bsi.ibss@hscni.net)

**This form allows you to apply for Stage 1 Chronic Hepatitis C payments where the person is deceased under the Wales Infected Blood Support Scheme.**

**All other forms are on our website:** [www.WIBSS.nhs.uk](http://www.WIBSS.nhs.uk)

If the deceased person was married, in a civil partnership, or a long-term relationship at the time of their death, their surviving partner may be eligible for support from the scheme too. In such cases the Estate of the deceased person must first have this application approved before the remaining partner can register with the scheme for support.

## HOW TO APPLY

This form must be completed by a person who is an Executor of the Estate of the deceased person, on behalf of all of the Executors where there is more than one. That person must first complete all parts in Section 1 of this form. The form should then be passed in its entirety to a medical professional, who will complete Sections 2-5. The medical professional must then send the completed form directly to the Wales Infected Blood Support Scheme.

Generally, the medical professional should be the principal clinician who treated the deceased person. This will probably be the clinician who treated them for Hepatitis C, but in the case of a deceased person who had bleeding disorders (such as haemophilia), it may be a haematologist.

If you have any records of how the deceased person was infected, please pass them to the medical professional who will be completing the remainder of the form.

## SUPPORTING DOCUMENTS REQUIRED

Please provide a copy of the Death Certificate for the deceased beneficiary. Once the application has been received from the medical professional, the Wales Infected Blood Support Scheme will contact you to obtain copies of other relevant documentation (for example, the deceased person's will, a copy of Confirmation from the court, etc, as appropriate).

## WHAT HAPPENS NEXT

When the medical professional has completed the form, they must send it along with copies of all relevant records direct to the Wales Infected Blood Support Scheme. Provided that the information supplied confirms eligibility to receive payment, you will receive a letter from the scheme to confirm this and will be asked to provide any further details required at that point.

***Please note; if your application is accepted, if any ongoing payments are due these will be backdated to the date that your application was received by WIBSS.***

Completed forms should be sent to:

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

## HELP WITH THIS FORM

If you require any assistance in completing this form, please contact the Wales Infected Blood Support Scheme on 02920 902280.

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\_\_\_\_\_

Print Name \_\_\_\_\_

## 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 your medical details requested in Sections 2 to 5 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 will be held in the strictest confidence and will be kept securely, in accordance with the Data Protection Legislation, and will not be shared with any other organisation. Velindre NHS Trust are a Data Controller under the Legislation 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. For further information on how we use your information, please see the Privacy Policy available on our website.

SECTION 1(B) APPLICATION DETAILS

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

Title

First Name

Middle Name(s)

Surname

Previous Names

Date of Birth

Address

Postcode

Home Telephone Number

Mobile Telephone Number

SECTION 1(C) DECEASED PERSON'S DETAILS

Title

First Name

Middle Name(s)

Surname

Previous Names

Date of Birth

Date of Death

Address  
(Main residence  
at date of death)

Postcode

Home Telephone Number

Mobile Telephone Number

SECTION 1(D) DECEASED PERSON'S ESTATE

Did the deceased person leave a will?

Yes  No

Has Confirmation been requested for the deceased person's estate?

Yes  No

If 'Yes', has Confirmation 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

Previous Names

Date of Birth

Address

Postcode

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Home Telephone Number

Mobile Telephone Number

What was their relationship to the deceased person?

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



SECTION 1(E) ADDITIONAL DETAILS

Do you believe the deceased person was infected with Hepatitis C 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, where and when you believe the infection occurred:

Do you believe this happened in a medical establishment in Wales?

Yes  No

**If Yes please continue, if No you may need to apply to one of the other UK schemes mentioned in the guidance notes above.**

Alternatively, do you believe they were infected with Hepatitis C 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 'No' this section is complete, if 'Yes' please provide further details below:

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How do you believe the infection occurred?

Who do you believe they received this infection from?

Title

First Name

Middle Name(s)

Surname

Previous Names

Date of Birth

Address  
(Must be main  
residence)

Postcode

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 remainder of the form. If you have any evidence to support this application, please also pass this on the medical professional. The medical professional will then send everything on to The Wales Infected Blood Support Scheme once completed.**

THE FOLLOWING SECTIONS MUST BE COMPLETED BY A MEDICAL PROFESSIONAL

GUIDANCE NOTES FOR MEDICAL PROFESSIONAL

Thank you for taking the time to 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 Hepatitis C.

**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 chronically infected with Hepatitis C

**AND**

- To confirm that the infection most probably arose through treatment with NHS blood, tissue or blood products. Treatment must have been received in Wales to join WIBSS.

If you can provide any evidence to support the above statements, then please attach copies to this form.

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 person who had been 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:

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

Please call us on **02920 902280** if you require anything

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) MEDICAL PROFESSIONAL'S DECLARATION

Registered Medical Practitioner's  
GMC registration number

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

Postcode

Telephone Number

Email Address

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

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

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

Yes  No

If 'Yes', please provide details below

Had the deceased person ever had a positive HCV antibody test?

Yes  No

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

Was the deceased person PCR/RNA positive at the time of death?

Yes  No

If the deceased person was PCR/RNA negative at the time of death, is this as a result of treatment they received for Hepatitis C?

Yes  No



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If the deceased person was PCR/RNA negative, is there radiological or pathological evidence that they were chronically infected after the acute phase (i.e. the first six months) of illness had passed? (Relevant radiological or pathological evidence would include chronic phase raised liver-function tests, previous consideration for treatment, liver histology or radiotherapy, other symptoms of chronic hepatitis)

Yes  No

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

SECTION 3(B) TO CONFIRM WHETHER THE INFECTION AROSE INDIRECTLY

In your opinion, is it probable that 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 <input type="checkbox"/>	No <input type="checkbox"/>
Accidental needle stick?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mother-to-baby transmission?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Other? Please specify

**PLEASE PROVIDE DETAILS AND A COPY OF TEST RESULTS TO CONFIRM WHICH GENOTYPE THE DECEASED PERSON WAS INFECTED WITH.**

**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 THOSE INFECTED WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS

Did the deceased person have an inherited or acquired bleeding disorder?  
(e.g. Haemophilia or Von Willebrand disease)

Yes  No

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

Whole blood or components (including platelets, red cells, neutrofilis etc.)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Cryoprecipitate	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Plasma/FFP	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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

Factor VIII concentrate	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Factor IX concentrate	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
FEIBA	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
DEFIX	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Fibrinogen	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Other coagulation factor concentrate	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If other coagulation factor concentrate, which?

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If any of the above treatments include repeated doses please specify below and indicate volumes used for each product if known.

In which medical establishment in Wales did the deceased person 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 the 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 IN WALES

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

In what NHS hospital in Wales or other facility is it believed infection occurred? (If the deceased person 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.

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

Albumin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Intravenous immunoglobulin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Plasma/FFP	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Bone marrow	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Whole blood or components (including platelets, red cells, neutrophils etc.)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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.)

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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, has the deceased person ever been treated for, or been involved with injecting drug use? (This could include having lived with, or been in a sexual relationship with, a person who injected drugs)

Yes  No

If 'Yes', please provide further details

Had the deceased person 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 for payment?

Yes  No

If 'Yes', please specify



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