Cynllun Cymorth Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

FORM C APPLICATION AND GUIDANCE NOTES

APPLICATION TO JOIN THE WIBSS SCHEME:
NEW HIV APPLICATION

GUIDANCE NOTES FOR APPLICANT

This form is for applicants who have never joined the Wales Infected Blood Support Scheme, or any of the UK Schemes or Legacy Schemes (e.g. MacFarlane Trust, Eileen Trust, MFET Limited) with regards to HIV payments, and either:

- Were infected with HIV as a result of treatment they received themselves with NHS blood, tissue, or blood products

Or

- Were infected with HIV as a result of the virus being transmitted from someone else, who themselves were infected with HIV as a result of treatment they received with NHS blood, tissue, or blood products

If your circumstances differ to the above, please contact the Wales Infected Blood Support Scheme for guidance. To apply to WIBSS you 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
Scottish Infected Blood Support Scheme: 0131 2756754
Northern Ireland Infected Blood Support Scheme: 028 9536 3817

This form allows you to apply for HIV payments under the Wales Infected Blood Support Scheme.

All other forms are on our website: www.WIBSS.nhs.uk

HOW TO APPLY

You should first complete all parts in Section 1 of this form. You should then pass this form in its entirety to a medical professional, who will complete the remaining sections. 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 treating you. This will probably be the clinician treating you for HIV, but in the case of applicants with bleeding disorders (such as haemophilia), it may be a haematologist.

If you do not have a clinician you can give this form to, you should ask your General Practitioner (GP) to complete it.

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

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 you are eligible to receive payment, you will receive a letter from the scheme to confirm this and will be asked to provide your bank details and any identification required at that point.

Please note; if your application is accepted, any payment due 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 02921 500900.

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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 have not received payment from any other UK scheme as a result of my HIV infection.

I agree to NHS Wales obtaining any data held on me by 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 me 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 my 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.

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SECTION 1(B) APPLICATION DETAILS

Title		First Name	
Middle Name(s)		Surname	
Previous Names		Date of Birth	
Address (must be main residence)			
		Postcode	

Home Telephone Number	
Mobile Telephone Number	
Email Address	
NHS Number	
National Insurance Number	

Married	☐	Civil Partnership	☐	Living with Partner	☐
Widowed	☐	Divorced	☐	Separated	☐
Single	☐				

Have you ever applied to any of the UK Legacy schemes (MacFarlane Trust, Eileen Trust, MFET Limited) to receive payments with regards to your HIV infection? If so please explain below.

SECTION 1(C) ADDITIONAL APPLICATION DETAILS

Do you believe you were infected with HIV as a result of treatment you received yourself with NHS blood, tissue, or blood products?

Yes ☐ No ☐

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

Do you believe this happened in a hospital setting 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 you 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 'No' this section is complete, if 'Yes' please provide further details below:
How do you believe the infection occurred?

Who do you believe you received this infection from?

Title		First Name	
Middle Name(s)		Surname	
Previous Names		Date of Birth	
Address (must be main residence)		Postcode	
What is your relationship to the person			

Have they ever registered with the Wales Infected Blood Support Scheme or any of the Legacy Schemes? (E.G MacFarlane Trust, Eileen Trust, MFET Limited) If Yes, please advice which scheme(s) if known:

SECTION 1(D) 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 your 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.

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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 patient 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 applicant had been chronically infected with HIV

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 applicant that you cannot answer, please consult other medical professionals who have treated the applicant and who would be able to provide the information. In some cases this form will concern a patient 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 **02921 500900** if you require anything.

SECTION 2(A) MEDICAL PROFESSIONAL'S DECLARATION

☐ **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_____

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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 have you known the 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

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 APPLICANT'S ELIGIBILITY

Are there any records to suggest the applicant has previously applied to another UK scheme (E.G MacFarlane Trust, Eileen Trust, MFET Limited) to receive payments with regards to their HIV infection?

Yes ☐ No ☐

If 'Yes', please provide details below:

Has the applicant 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 THE 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 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 ☐

Please provide details and 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 THOSE INFECTED WITH HAEMOPHILIA OR OTHER INHERITED OR ACQUIRED BLEEDING DISORDERS

Does the applicant have, or is a carrier of, 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 applicant 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 treatments used to treat the applicant 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?

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

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

If none of the products listed above was used to treat the applicant before September 1991, do you think it is probable that the applicant's HIV 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 applicant'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).

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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 applicant 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 applicant 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, neutrophils 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.) 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 applicant 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 injects or injected drugs)

Yes ☐ No ☐

If 'Yes', please provide further details

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 applicant 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 applicant's HIV 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