NHS
Business Services Authority

England Infected Blood Support Scheme (EIBSS)
Special Category Mechanism (SCM) application form

Notes to applicants

To make an application to the SCM, you must:

- **already have made a successful hepatitis C stage 1 payment application to EIBSS; and**
- **have one of the specific hepatitis C associated conditions listed in Section 5 or believe that your hepatitis C infection, or its treatment, complications, or a condition caused by the infection is affecting your ability to carry out everyday activities.**

This SCM process allows stage 1 beneficiaries to apply for the higher annual payments, equivalent to HIV and hepatitis C stage 2 annual payments.

If you have already successfully applied to the Scheme and have been diagnosed with advanced cirrhosis, primary liver cancer, have been offered or are in receipt of a liver transplant, have B-cell non-Hodgkin's Lymphoma or have Type 2 or 3 Cryoglobulinaemia (only accompanied by membranoproliferative glomerulonephritis (MPGN)), you will already be receiving hepatitis C stage 2 annual payments and so this process does not apply to you. Please speak to the NHS Business Services Authority (NHSBSA) for further advice about this if you are unsure.

If you find you do not qualify for stage 2 payments, you may complete this application form.

To complete this application form, it is important that you contact your hospital consultant or viral hepatitis nurse to discuss the application and the accompanying guidance notes. If you are not under the care of a hospital doctor or viral hepatitis nurse, please contact the NHS Business Services Authority (NHSBSA) who will be able to advise further. Your GP may be an acceptable alternative, but we would prefer the evidence to come from the hospital service treating you.

Please note that you and your doctor/nurse must complete:

- Section 4
- **Either** Section 5 or Section 6

You also need to complete Sections 1 and 2 and your doctor/nurse must also complete Section 7.

Please read these notes carefully before completing the form.

How to complete the form

You will need to contact your hospital consultant or viral hepatitis nurse to complete the form, as your application will need their medical evidence to confirm the associated condition or the impact the infection is having. Together you will need to complete, sign, and date the form before sending it to us.

We would prefer the evidence to come from the hospital service treating you, however if you are not being seen by a hospital doctor or viral hepatitis nurse, your GP may be an acceptable alternative. Please contact the NHSBSA by telephone on 0300 330 1294, by email to *eibss@nhsbsa.nhs.uk*, or in writing to:

FREEPOST EIBSS (valid within the UK only) or to EIBSS, NHSBSA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN.

who will be able to advise you about who could help you with this form. If you have to pay to obtain medical evidence at this stage, the NHSBSA will pay you back in full.

Please complete:

- The declaration at Section 4; and
- **either** Section 5 or Section 6 (whichever of the two is the most appropriate to your situation).

Section 4 contains declarations for you and your doctor/nurse to complete and sign.

Please read everything carefully as a partially completed form may have to be returned to you and will delay the processing of your application.

Complete Section 5 of the form if you have one of the diseases listed there.

If the evidence confirms that you have one of the conditions listed at the start of Section 5, you will be successful in your application.

You must:
- sign and date the declaration at Section 4A; and
- complete Section 5A.

Your doctor (or viral hepatitis nurse) must:
- sign and date the declaration at Section 4B;
- complete Section 5B and provide supporting medical evidence; and
- provide an overall clinical assessment at Section 7.

Complete Section 6 with the help of your doctor or viral hepatitis nurse if you do not have any of the diseases listed in Section 5.

You must:
- sign and date the declaration at Section 4A; and
- complete Section 6A.

Your doctor (or viral hepatitis nurse) must:
- sign and date the declaration at Section 4B;
- complete Section 6B and provide supporting medical evidence; and
- provide an overall clinical assessment at Section 7.

Section 6 looks at whether your infection, or its treatment or complications, are causing mental health problems or tiredness that affect what you can do, day to day. The form asks for supporting statements about this from you and your doctor or nurse.

To be successful in your application, the evidence must show that any impact is substantial and long-term.

Your doctor or viral hepatitis nurse will also be asked to assess how likely it is that any problems you have are caused by your infection (and not something else). If you and those treating you do not agree over the evidence provided, then the evidence submitted will be reviewed by an independent panel of experts.

Section 7 asks your doctor or nurse to provide an overall clinical assessment of your condition and its impact on your ability to carry out daily activities. Evidence from your medical records is also requested.

Your doctor or nurse is being asked to assist with this process because he/she will know the status of your health best and will have the evidence required.

If you are in doubt about your eligibility for SCM payments, you should contact the NHSBSA for advice.

Other important information

The evaluation made by your treating doctor/nurse is important. However, we recognise that it may not always be possible for them to provide factual evidence from your medical records. In such cases their clinical judgement may be enough to allow the NHSBSA to decide your case.

If your application is rejected, you will have the chance to appeal the decision. A panel of independent experts will look at your application and all accompanying evidence. However, the decision then made by the experts will be final and you will not be able to appeal against their decision. In such cases you will be eligible to reapply after a period of six months, taken from the date that your original application was received. It is expected that further applications will include additional evidence that was not provided in the original application.

If you disclose in this application form that you are in receipt of any state benefits, this will not affect your entitlement to any support you are applying for in this application.

Notes for doctors or viral hepatitis nurses completing the application form

The EIBSS was set up by the Department of Health to help those infected with hepatitis C and/or HIV through NHS supplied blood or blood products before 1991.

Your patient has arranged to meet with you because they consider their chronic hepatitis C infection acquired through NHS supplied blood or blood products, or its treatment, or a specific causally linked hepatitis C associated condition (listed in Section 5 of the form), is having a substantial and long-term adverse effect on their ability to carry out day-to-day activities. They are seeking your help to provide evidence to support this so they can claim increased annual payments from the EIBSS as a stage 1 beneficiary.

Your role is important in providing the evidence and/or endorsement of the impact hepatitis C is having on your patient.

- Section 5 of this application process asks the applicant if they have been diagnosed with one of the diseases listed.

- Section 6 is only applicable if the applicant has not been diagnosed with one of the diseases listed, and asks if the applicant has mental health problems or chronic fatigue as a result of their hepatitis C, which is impacting on their ability to carry out daily activities.

Please ensure your patient has completed the appropriate section and provide evidence of this and whether they have required treatment (e.g. anti-depressants or other therapies).

Please then provide an overall clinical assessment at Section 7 then sign the declaration.

We appreciate that some of what is being sought by way of evidence may be subjective and therefore difficult for you to provide and some answers may rely on asking you to exercise your professional judgment. You may wish to seek further evidence from other people treating your patient.

If you have any questions or queries related to this process, please contact the NHSBSA for advice on 0300 330 1294. They will be able to provide you with further details and answer any questions you may have about this process.

Section 1 - Applicant's details

Title:

First name:

Last name:

Date of birth: / /

EIBSS reference number (if you already have one):

Marital/civil partnership status:

Address (including postcode):

Postcode

Mobile number:

Landline number:

We will ask you to supply relevant supporting evidence if you are applying on behalf of a recipient. For example, this may include a Power of Attorney or a signed letter from a GP. If you're unsure what evidence to supply please contact us at *eibss@nhsbsa.nhs.uk* or on 0300 330 1294, or you can write to us at FREEPOST EIBSS (valid within the UK only) or at EIBSS, NHSBSA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN.

Section 2 - Contact preferences

Please indicate your preferred method by which we may contact you with essential information about the Scheme by ticking the relevant box(es) below:

I prefer to be contacted by: ☐ letter ☐ telephone ☐ email

Please let us know if you need your letter in a specific format:

If you are happy for us to write to you, where would you like us to send any letters?:

☐ My home address

☐ An alternative address (please provide below)

Postcode

If you have indicated that you are happy for us to contact you by telephone or email, please provide the details you'd like us to use here:

Landline telephone number:

Mobile telephone number:

Email address:

Section 3 - Data Protection

By submitting this form to the NHSBSA, you confirm that you have read and understood the privacy notice at the end of this form.

Your personal information will only be used by the NHSBSA on behalf of the Department of Health, to check your eligibility for a payment and to administer your application. In the event that you appeal a decision, your information may be disclosed to a panel of experts. Information about the NHSBSA's privacy policy is available at *www.nhsbsa.nhs.uk/our-policies/privacy*. All personal information will be transferred and stored securely in compliance with Data Protection law.

By submitting this form to a medical professional, you consent that your medical details necessary to evidence your application will be supplied to the NHSBSA for the purpose of administering your application. If your application is deemed to be ineligible, the Scheme will keep your application form on file for up to ten years so that it has a full historical record in the event that you lodge an appeal or if you reapply for a payment. If you have any questions regarding the use of your information, please contact the Scheme administrator, by telephone on 0300 330 1294, by email to *eibss@nhsbsa.nhs.uk*, or in writing to:

FREEPOST EIBSS (valid within the UK only) or to EIBSS, NHSBSA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN.

Section 4A - Applicant Declaration (to be completed by you/your representative)

Declaration: I confirm that the information given in this application form is, to the best of my knowledge and belief, correct and complete. I understand and consent to the sharing of information relating to my medical condition with assigned expert group members of the NHS Business Services Authority for the purposes of applying for increased annual payments and with the NHS Counter Fraud Authority for the purposes of verification of this claim and the investigation, prevention, detection and prosecution of fraud. I understand that if I knowingly give false information, support will be stopped and I may be asked to return any financial support given to me as a result of this application and that I may be liable for prosecution and civil recovery proceedings.

Please note: Failure to provide requested further information within a three-month period will result in a new application being required.

Signed:

Date:

		/			/				

Section 4B - Medical Practitioner Declaration (to be completed by your doctor or viral hepatitis nurse)

Declaration: By signing this form I confirm that the information contained within Sections 5 and/or 6 and 7 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 for prosecution. I consent to the disclosure of information from this form to and by the NHS Business Services Authority and NHS Counter Fraud Authority for the purpose of verification of this claim and for the investigation, prevention, detection and prosecution of fraud.

Signed:

Date: / /

Identity and authority of the medical practitioner completing the relevant sections of the form

Name of medical practitioner:

Hospital:

Job title:

Address:

Department:

When did you last see the applicant? / /

Postcode

Telephone number:

Mobile number:

Email address:

If Section 4B was completed by a viral hepatitis nurse, this box should be signed by a hospital consultant hepatologist to verify the information and evidence provided by the nurse.

GP practice stamp:

Section 5A - To be completed by you

Do you have any of the following conditions? Please discuss with your hospital specialists (Tick all that apply)

If none of these apply, please go to Section 6.

	Condition	**Please tick**	**Date of diagnosis**
A	Autoimmune disease due to, or worsened by, interferon treatment for hepatitis C, for example:	☐	/ /
A1	• Coombes positive haemolytic anaemia	☐	/ /
A2	• Idiopathic fibrosing alveolitis of the lung	☐	/ /
A3	• Rheumatoid arthritis	☐	/ /
B	Sporadic porphyria cutanea tarda causing photo-sensitivity with blistering	☐	/ /
C	Immune thrombocytopenic purpura with anti-platelet antibodies	☐	/ /
D	Type 2 or 3 mixed cryoglobulinaemia, which is accompanied by:	☐	/ /
D1	• Cerebral vasculitis	☐	/ /
D2	• Dermal vasculitis	☐	/ /
D3	• Peripheral neuropathy with neuropathic pain	☐	/ /

Section 5B – To be completed by your doctor or viral hepatitis nurse

Please provide confirmation that the applicant is suffering with the diagnosis or diagnoses ticked in the list above and include evidence from the applicant's medical records.

If you wish to add more information, please attach to the back of this application form.

Section 6A - To be completed by you (if you do not have any of the listed conditions in Section 5)

Please provide information on how your infection, or its treatment and possible complications, affect your daily living. Section 6 has two questions which ask whether the impact of your hepatitis C or its treatment affects your ability to carry out daily activities because of a) mental health problems or b) chronic fatigue.

Please answer **at least one** of these questions.

Q1. Does your hepatitis C infection or its treatment make it difficult for you to carry out daily activities, such as leaving your home, using public transport or shopping for essentials, as a result of mental health problems (such as feeling depressed or anxious)?

☐ Yes ☐ No

Please say **how often** this affects you? (Tick one box)

☐ Occasionally ☐ At least monthly ☐ At least weekly ☐ Most days of each week/daily

Please say how substantial the impact of the above is on your ability to carry out day-to-day activities. Please give clear descriptions of how you are affected and examples, and how long you have been experiencing this. If you wish to add more information, please attach to the back of this application form.

(Maximum word limit 500)

Q2. Does your hepatitis C infection or its treatment make it difficult for you to carry out regular daily activities, such as walking more than 50 metres, climbing stairs, lifting objects from the ground or a work surface in the kitchen or physical tasks such as cooking as a result of feeling chronically fatigued?

☐ Yes ☐ No

Please say **how often** this affects you? (Tick one box)

☐ Occasionally ☐ At least monthly ☐ At least weekly ☐ Most days of each week/daily

Please say how substantial the impact of the above is on your ability to carry out day-to-day activities. Please give clear descriptions of how you are affected and examples, and how long you have been experiencing this. If you wish to add more information, please attach to the back of this application form.

(Maximum word limit 500)

Section 6B – To be completed by your doctor or viral hepatitis nurse

Please confirm that, in your experience of the applicant, their hepatitis C infection (or its treatment or complications) is making it difficult for them to carry out regular daily activities **as a result of mental health problems**.

Please state a) which mental health problems, b) how long these mental health problems have been going on for, and c) their expected duration. If your patient has been receiving treatment for mental health problems (e.g. medication, counselling, other therapies), then please provide any evidence you have on this.

In your opinion, how likely is it that your patient's mental health problems are attributable to their hepatitis C infection (or its treatment or effects)? (Tick one box)

☐ Not likely – explained by other causes ☐ Possible ☐ Highly likely ☐ Definite

If you wish to add more information, please attach to the back of this application form.

(Maximum word limit 500)

Please confirm that, in your experience of the applicant, their hepatitis C (or its treatment or complications) is making it difficult for them to carry out regular daily activities **as a result of chronic fatigue**.

Please state how long this chronic fatigue has been going on for, and its expected duration.
If your patient has been receiving treatment for fatigue (e.g. medication, counselling, other therapies), then please provide any evidence you have on this.

In your opinion, how likely is it that your patient's fatigue is attributable to their hepatitis C infection (or its treatment or effects)? (Tick one box)

☐ Not likely – explained by other causes ☐ Possible ☐ Highly likely ☐ Definite

If you wish to add more information, please attach to the back of this application form.

(Maximum word limit 500)

Section 7 - To be completed by your doctor or viral hepatitis nurse

Overall clinical opinion

Please confirm that, in your clinical judgement, it is likely that your patient's hepatitis C infection, (or its treatment or complications) is having a substantial and long-term adverse impact on their ability to carry out daily activities.

Please give an opinion on the following scale to say whether the difficulty in carrying out regular daily activities is likely to be attributable to the hepatitis C infection or its effects (tick one box)

☐ Not likely – explained by other causes ☐ Possible ☐ Highly likely ☐ Definite

Clinical assessment (Maximum word limit 500) If you wish to add more information, please attach to the back of this application form.

Final steps

Please return this form and all required evidence to: FREEPOST EIBSS (valid within the UK only) or to EIBSS, NHSBSA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN.

All personal data acquired by the NHSBSA from this application form shall only be used for the purposes of this process and shall not be further processed or disclosed without the consent of the above signed applicant.

Please note:

- The declaration must be signed and dated by both you and your medical practitioner (doctor or hepatitis nurse).
- Partially completed forms may be returned to you (unless the questions you omit are not relevant to you).
- Forms without a professional assessment (Section 7) cannot be considered.
- Receipt of this form does not guarantee your application will be approved.
- If you do not provide appropriate evidence, or your application is not straightforward, then the NHSBSA can reject your application and you will be notified in writing.
- If the NHSBSA turns down your application, you will be able to appeal. An independent appeal panel will then have the final say on your application and you will not be able to appeal their decision. But you will have the chance to reapply at a later date, or if you can provide evidence that your condition has worsened since last submitting this for assessment.

England Infected Blood Support Scheme - Privacy notice

The NHSBSA will process the information supplied by the charities who previously provided the service for the purposes of administering payments under the EIBSS.

The NHSBSA is providing this service, as it is legally obliged to do so under the NHS Business Services Authority (Awdurdod Gwasanaethau Busnes y GIG) (Infected Blood Payments Scheme) Directions 2017.

The NHSBSA can be contacted at the following address: FREEPOST EIBSS (valid within the UK only) or to EIBSS, NHSBSA, Bridge House, 152 Pilgrim Street, Newcastle-upon-Tyne, NE1 6SN.

Data sharing

Your information may be shared with other people/organisations including, but not limited to, the following:

- Administrators of other Infected Blood Support Schemes in the UK to ensure you are directed to the correct scheme.
- Medical professionals for the assessment of any future applications/appeals made.
- The Department of Health for planning and information purposes.

The information may be shared for the purposes of preventing fraud and error.

By accepting this information and continuing with your claim you consent to the disclosure of relevant information to the NHSBSA and any other relevant parties they may share it with as outlined above.

Your information will not be transferred outside the EU unless you, at any time, reside outside of that area and the transfer is required in order to write to you regarding the service and/or to make payments to the appropriate bank.

How long we will keep your information

Your information will be retained for seven years following the date of the final payment being made to you or any of your dependents.

Your rights

Information you provide to the NHSBSA will be managed as required by relevant Data Protection law including the General Data Protection Regulation (GDPR).

You have the right to:

- Receive a copy of the information the NHSBSA holds about you.
- Request your information be changed if you believe it was not correct at the time you provided it.
- Request that your information be deleted if you believe the NHSBSA is processing it for longer than is necessary to make payments under the EIBSS.

Details of how the NHSBSA processes your data are shown on our website at *https://www.nhsbsa.nhs.uk/our-policies/data-protection*

To make use of these rights please contact the NHSBSA Data Protection Officer:

Head of Internal Governance
NHS Business Services Authority
Stella House
Goldcrest Way
Newburn Riverside
Newcastle upon Tyne
NE15 8NY

dataprotection@nhsbsa.nhs.uk

If you have any concerns about the processing of your information you have the right to contact the Data Protection Regulator:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF

https://ico.org.uk/global/contact-us/email/
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