NHS
Business Services Authority

England Infected Blood Support Scheme (EIBSS)
Application form for support payments for those infected with HIV through blood, blood products or tissue transfer.

Notes to applicants

Please read this information carefully before completing Sections 1 – 6 then pass the form to the medical professional you will be asking to complete the rest of the form.

How to complete the form

To the applicant

1. Please complete and sign Sections 1 – 6 of the form. You only need to complete Section 6 if you are applying because you acquired HIV from someone else infected through blood or tissue transfer.
2. Ask the consultant whose care you are currently under to complete the rest of the form if they have not already done so.

   or

   If you cannot ask your consultant please give as much detail as possible in Sections 7 and 8 and send the form to the address below.

   If you complete Section 6 you do **not** need to complete Section 8.
3. By submitting this form to the NHS Business Services Authority (NHSBSA), you confirm that you have read and understood the privacy notice at the end of this form.

To the registered medical practitioner

1. Please ask the applicant (or representative) to complete Sections 1 – 6 as relevant.
2. Please complete Sections 7 - 9 as far as possible from the case notes available to you or by asking the applicant or their representative. Please sign Section 10.

Please send the completed form to the address given below with copies of evidence about your HIV infection wherever possible. This will allow us to identify the source of your HIV infection and/or assess your application on the balance of probabilities.

FREEPOST EIBSS (valid within the UK only) or EIBSS, Skipton House, 80 London Road, London, SE1 6LH.

Section 1 - Applicant's details

Title:

First name:

Last name:

Address (including postcode):

Postcode

Date of birth: / /

Mobile number:

EIBSS reference number (if you already have one):

Landline number:

Marital/civil partnership status:

National Insurance number:

If applying on behalf of the estate if the applicant is deceased, what is or was your relationship to this person?:

If the applicant is deceased and you have not already supplied the EIBSS with a copy of the death certificate please attach a copy to this form.

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 *nhsbsa.eibss@nhs.net* or on 0300 330 1294, or you can write to us at FREEPOST EIBSS (valid within the UK only) or at EIBSS, Skipton House, 80 London Road, London SE1 6LH.

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

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)

Post code

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

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 - For living applicants only

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 *nhsbsa.eibss@nhs.net*, or in writing to:

FREEPOST EIBSS (valid within the UK only) or to EIBSS, Skipton House, 80 London Road, London SE1 6LH.

Section 4 - Declaration

I am the applicant named above / I am a representative of the applicant named above and state that the information on this form (Sections 1 - 9) is true to the best of my knowledge and belief.

I give permission for my medical practitioner to discuss my case with officials of the Department of Health and its medical advisors and for them to contact relevant bodies such as NHS Blood and Transplant regarding information about the blood product I received. I also consent to the disclosure of my details records by my general practitioner and the relevant hospital to my case.

I understand that any discussions and records will be treated in confidence and restricted to those who need to know for the purposes of considering this application.

I consent to a medical examination and/or blood test if required by the reviewer(s) of my application.

Signature of applicant/applicant's representative:

Date:

		/			/				

Section 5 - Personal details

Present marital status (single, married, civil partnership, divorced, widowed)

Is your marital status the same as when you think the infection occurred? ☐ Yes ☐ No

If no, please give status on that date

Have you changed your name since the time when you think the infection occurred? ☐ Yes ☐ No

If yes, what was the name you were known by at that time?

Have you changed your name since you received the first positive HIV test? ☐ Yes ☐ No

If yes, what was the name you were known by at that time?

Where did you live when you think the infection occurred (if different from current residence)? (Please provide full address)

Postcode

Where did you live on the date when you received the positive HIV test (if different from current residence)? (Please provide full address)

Postcode

Children

Did you have any dependent children at the time when you think the infection occurred and at the time of your first positive HIV test? ☐ Yes ☐ No

(Please give name(s) and date(s) of birth)

Name	**Date of birth**
	/ /
	/ /
	/ /
	/ /

Information about the HIV infection

How do you think you were infected with HIV?

When do you think you were infected with HIV? Please be as precise as possible. | | | / | | | / | | | | |

Where do you think you were infected with HIV? Please give hospital address (if you are an infected intimate, please see also Section 2).

Postcode | | | | | | | | |

When did you receive your first HIV-positive result? | | | / | | | / | | | | |

If you think you were infected with HIV some years ago, why did you not come forward sooner?

Please describe any other factors that might be relevant, e.g. any drug use, association with people or groups in or from countries with high prevalence of HIV etc.

Section 6 - To be completed only if you are applying because you acquired HIV from another person infected through blood (products) or tissue

Title:

First name:

Last name:

Address (including postcode):

Postcode | | | | | | | | |

Relationship with you: ☐ Spouse ☐ Partner ☐ Parent

Has this person or their representative already applied for a payment under the Scheme?

☐ Yes ☐ No ☐ Not known

Date applied (if known) | | | / | | | / | | | | |

Is this person still alive? ☐ Yes ☐ No ☐ Don't know

If yes, please note that we will need to approach him/her regarding this application. Please supply an address or other contact details (if different from the above).

Postcode | | | | | | | | |

Section 7 - Details of HIV infection (for completion by GP/consultant)

Is the applicant HIV positive (or was positive if since died)? ☐ Yes ☐ No

Date of first positive test: | | / | | / | | | | |

Please give name and address of the applicant's consultant and medical facility where the first positive test was conducted.

Postcode | | | | | | | | |

Please give name and address of the applicant's current consultant and medical facility (if different)

Postcode | | | | | | | | |

Is the clinical/laboratory evidence consistent with the time (and type) of infection identified by the applicant? ☐ Yes ☐ No (please give details if possible)

Did she/he die of AIDS? ☐ Yes ☐ No

Is there any other evidence to suggest s/he may have been infected with HIV? ☐ Yes ☐ No

If yes, please give details

Section 8 - Details of blood transfusion, organ or tissue transplant or treatment with blood products (for completion by GP/consultant)

Type of treatment thought to have resulted in HIV infection in the applicant:

☐ Blood transfusion (e.g. component or whole blood)

☐ Organ / tissue transplant

☐ Blood product (please give details)

☐ Other (please give details)

Details

What was the transplant/type of blood/product given?

Date of transfusion, transplant, or treatment with blood product:

		/			/				

If the patient has haemophilia, between what dates did he/she receive plasma derived blood products?

Reason for transfusion, transplant or treatment with blood product:

Name of the applicant's consultant at the time the infection is thought to have occurred (if known)

Applicant's consultant's hospital address (if known)

Postcode

If person has received more than one transfusion, transplant or treatment, please give dates/hospital for each.

Section 9 - Additional details (for completion by GP/consultant)

Please give details of any other (risk and behavioural) factors that may possibly be relevant to the applicant's HIV infection, for example attendance at Genito-urinary Medicine Clinic (other than to take an HIV test), Drug Dependency Unit, association with people in or from countries which high prevalence of HIV, etc.

Section 10 - Declaration (Consultant)

I am a registered medical practitioner and have discussed the questions on this form with the applicant or their representative (if the patient is deceased or unwell) and to the best of my knowledge and belief the answers given on this form (Sections 1-9) are true.

Signed:

Name of Consultant/GP/other:
(please delete as appropriate)

GP's GMC number:

Date:

		/			/				

Address of hospital or practice:

Postcode								

Note: Please append any documentary evidence about the applicant's HIV infection wherever possible. This will enable us to identify the source of the HIV infection and/or assess the application on the balance of probabilities.

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 at EIBSS, Skipton House, 80 London Road, London SE1 6LH.

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

nhsbsa.dataprotection@nhs.net

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/
https://ico.org.uk/