



葵青區議會  
KWAI TSING DISTRICT COUNCIL



FOR OFFICE USE ONLY	
Receipt Date	
Ref. No.	
Verified by	

## 葵青社區重點項目及社區參與計劃 Kwai Tsing Signature Project Scheme and Community Involvement Programme 牙科護理服務及視光/眼睛檢查服務申請表格

Dental Care Service and Optometric/Ocular Examination Service Application form

### 注意事項 Notice

- 申請人只可就每項服務遞交一次申請表格。填寫本表格前，請細閱〈申請須知〉。  
Each person is allowed to submit only one application form for each service. Please read "Notes for Applicants" carefully before completing this form.
- 申請人必須於葵青區居住，並年滿 60 歲（牙科護理服務適用）或 50 歲（視光/眼睛檢查服務適用）（請見〈申請須知〉第 3 至 4 項）。  
Applicants must reside in Kwai Tsing and aged 60 or above (for dental care service) or 50 or above (for optometric/ocular examination service) (Please refer to Notes 3 & 4).
- 〈申請須知〉第 4(ii)項所列明之資助項目的現有受惠人，不符合此項服務的申請資格。該些資助項目開列如下：  
Current beneficiary of subsidy schemes listed in Note 4(ii) is **NOT eligible** for the Service. These subsidy schemes are set out below:  
(1) 綜合社會保障援助 Comprehensive Social Security Assistance Scheme;  
(2) 《公務員事務規例》所列明的公務員醫療及牙科福利；或  
Civil Service Medical and Dental Benefits as set out in Civil Service Regulations; or  
(3) 關愛基金長者牙科服務 [只適用於牙科護理服務申請]。  
Community Care Fund Elderly Dental Assistance Programme [for dental care service application only].
- 遞交申請表格時必須附上載有申請人姓名的居住地址證明副本，如：電費單、差餉單、銀行月結單、選民登記通知書及公屋租約等（除公屋租約外，有關文件須於最近三個月內發出）。  
Applicants are required to submit a **copy of proof of residential address bearing their names**, such as electricity bill, rates bill, bank statement, voter registration notification, public rental housing tenancy agreement (The documentary proof must be issued within recent three months except for public rental housing tenancy agreement).
- 每個階段的截止申請日期請見〈申請須知〉第 4(vii)項。  
For the respective application deadline of each phase, please refer to Note 4(vii).
- 如申請人欲收取〈認收通知書〉，必須於遞交表格時連同一個貼上港幣 2 元郵票並寫上回郵地址的信封（詳見〈申請須知〉第 4(vi)項）。  
Applicants requiring an "Acknowledgement of Receipt" should return the application form, together with one self-addressed stamped (HK\$2) envelope (Please refer to Note 4 (vi)).
- 請以中文或英文正楷填寫所有項目，並在適當方格內加上「✓」。  
This form must be completed in Chinese or English in BLOCK letters. Please tick the box(es) as appropriate.

本人欲申請之服務： I would like to apply for the following service(s): (可選多於一個 You can choose more than one option)

牙科護理服務 Dental Care Service\* (自2018年1月1日起民政處收到的申請將暫不會處理，直至該日(即2018年1月1日)之前收到的所有申請已接受服務為止。)

視光/眼睛檢查服務

Optometric/Ocular Examination Service

甲部 Section A. 申請人資料 Particulars of Applicant (須與香港身份證上資料相同 as stated on Hong Kong Identity Card)

中文姓名 Chinese Name : \_\_\_\_\_ 英文姓名 English Name : \_\_\_\_\_

出生日期 Date of Birth :         性別 Sex :  男 Male  女 Female

香港身份證號碼 HK Identity Card No. :       ( ) 聯絡電話 Contact No. : \_\_\_\_\_  
(所填寫的電話號碼將作預約之用。可填寫多於一個。)  
(For appointment booking only. You can fill in more than one number.)

居住地址 Residential Address : \_\_\_\_\_ (室 Flat/Room) \_\_\_\_\_ (樓 Floor) \_\_\_\_\_ (座 Block)

請夾附地址證明副本  
A copy of proof of residential address must be enclosed

(大廈 Building)  葵涌 Kwai Chung  
 青衣 Tsing Yi  
Street/Estate/Village

## 乙部 Section B. 申請人聲明 Declaration by Applicant

本人已閱讀〈申請須知〉，並明白及同意與此申請有關的安排如審核程序、預約服務及應診安排等。就此申請，本人承諾及保證會遵從在〈申請須知〉內列出的所有規定，並謹此聲明：

I have read "Notes for Applicants". I understand and agree to the arrangements in relation to the application such as vetting procedures, appointment booking and attendance rules, etc. I hereby undertake and warrant that I shall comply with all requirements set out in the "Notes for Applicants" in making this application, and declare the following:

(一) 本人並非〈申請須知〉第4(ii)項所列明之資助項目的現有受惠人。該些資助項目開列如下:-

I am not a current beneficiary of the subsidy schemes listed in Note 4(ii) as set out below:-

- (1) 綜合社會保障援助 Comprehensive Social Security Assistance Scheme;
- (2) 《公務員事務規例》所列明的公務員醫療及牙科福利；或  
Civil Service Medical and Dental Benefits as set out in Civil Service Regulations; or
- (3) 關愛基金長者牙科服務 [只適用於牙科護理服務申請]。  
Community Care Fund Elderly Dental Assistance Programme [for dental care service application only].

(二) 本人在本表格內所填報的資料，均屬真確無訛。本人明白蓄意隱瞞、漏報或虛報資料，以圖令本人取得(i)葵青社區重點項目(『項目』)；(ii)葵青社區參與計劃(『計劃』)；及(iii)其他由葵青區議會或葵青民政事務處推行的健康服務計劃(『其他健康服務』)的服務或資助，可能屬刑事行為。除會導致本人喪失申請資格外，本人更可能因觸犯盜竊罪條例(香港法例第210章)或其他有關法例而被起訴。

The information provided in this form is true and correct. I understand that knowingly or willfully making any false statement or withholding any information for the purpose of obtaining service or subsidy under (i) the Signature Project Scheme ("the Scheme"), (ii) the Community Involvement Programme ("the Programme") and (iii) other Healthcare Services launched by Kwai Tsing District Council or Kwai Tsing District Office ("the other Healthcare Services") may be a criminal act. Such act not only may cause myself ineligible for the Service(s), I may also be liable to prosecution under the Theft Ordinance (Cap. 210 of the Laws of Hong Kong) or any other relevant Ordinances.

(三) 本人授權及同意葵青民政事務處(『民政處』)根據〈申請須知〉第7項處理及使用本人的資料，進行與本人就此項目、計劃或其他健康服務遞交的申請有關的用途包括作出審核，並同意民政處在處理本申請時，在有需要必須披露本人資料的情況下，可向其他各方(包括社會福利署、公務員事務局、其他政府決策局/部門及/或有關機構及其授權人員)披露本人的個人資料，以處理本人就此項目、計劃或其他健康服務遞交的申請。本人明白處理申請的審核程序包括確定本人是否符合〈申請須知〉第4(ii)項列明的受惠資格，並同意上述決策局/部門(包括社會福利署及公務員事務局)/機構/授權人員可向民政處披露本人是否符合上述受惠資格(例如本人是否綜合社會保障援助及/或《公務員事務規例》所列明的公務員醫療及牙科福利的現有受惠人)；如本人不符合資格，將不得接受此項目、計劃或其他健康服務的服務。

I hereby authorize and give consent to Kwai Tsing District Office ("the District Office") to handle and use my data in accordance with Note 7 for the purposes of the application submitted by me including the conduct of checking. I consent to the disclosure of my personal data by the District Office to any other parties (including Social Welfare Department, Civil Service Bureau, other relevant government bureaux/departments and/or relevant organizations and their authorized officers) in relation to the application submitted by me if the disclosure is necessary for processing of my application. I understand the processing of my application would include the conduct of checking procedure for ascertaining whether I am eligible under the Scheme, the Programme and the other Healthcare Services as stated in Note 4(ii) and consent to the disclosure of the eligibility (such as whether I am current beneficiary of Comprehensive Social Security Assistance Scheme and/or Civil Service Medical and Dental Benefits as set out in Civil Service Regulations) by the aforesaid government bureaux/departments (including Social Welfare Department and Civil Service Bureau) /organizations/authorized officers to the District Office. I understand that I may not receive service under the Scheme, the Programme and the other Healthcare Services in case I am ineligible.

申請人/監護人簽署:

Signature of Applicant/Guardian: \_\_\_\_\_

日期 Date: \_\_\_\_\_

(如申請人不會讀寫，請印下指模  
or a finger print if Applicant is illiterate)

**如申請人精神上有能力行事但不會讀寫，見證人須填寫此欄**

**Complete by Witness only if Applicant is mentally capable but is illiterate.**

本人見證這份表格已在申請人面前朗讀及解釋 This document has been read and explained to the applicant in my presence.

見證人姓名 Name of witness : \_\_\_\_\_ 香港身份證號碼 HK Identity Card No. : \_\_\_\_\_

見證人簽署 Signature of witness : \_\_\_\_\_ 日期 Date : \_\_\_\_\_

**如申請人精神上無能力行事而申請是由監護人代其作出，監護人須填寫此欄**

**Complete by Guardian only if the application is made on behalf of Applicant who is mentally incapable**

監護人姓名 Name of guardian : \_\_\_\_\_ 香港身份證號碼 : \_\_\_\_\_

HK Identity Card No. \_\_\_\_\_