In Collaboration with:

# FORM A/ BORANG A

**POSITIVE AUDACIOUS LIVING (PAL SCHEME)**

**MEDICINE ASSISTANCE SCHEME**

The PAL Scheme is a medical assistance programme run by the Malaysian AIDS Foundation (MAF).

Initiated in 1998, the scheme provides underprivileged Malaysians living with HIV/AIDS the opportunity to undergo antiretroviral (ARV) treatment with the primary objectives of helping them prolong their lifespan and improving their quality of life.

The ARV treatment is the current state-of-the-art approach in HIV clinical management that combines two nucleoside reverse transcriptase inhibitors (NRTIs) with drugs from another class such as non-nucleoside reverse transcriptase inhibitors (NNRTIs) or protease inhibitors (PIs).

This treatment combination has been shown to produce a more potent and sustained suppressive effect on HIV replication. By doing so, the HIV viral load will be kept at low and sometimes, undetectable levels which in turn will improve patient survival.

## PATIENT'S ELIGIBILITY CRITERIA

### *a)* Medical Criteria

- A CD4 cell count of 350 or less on two occasions taken at least one month apart (the date of the test should not be any earlier than two months from the date of application).
- Good compliance with clinical follow-up and therapy.
- No immediate life-threatening illness with a life expectancy of at least 6 months.
- No other (non-HIV) terminal diseases e.g. cancer, end-stage renal disease, late liver disease etc.

### *b)* Non-Medical Criteria

- Malaysian.
- Above the age of 17.
- A monthly household income of RM 3,000 nett and below.

## NOMINATION, SELECTION & ACCEPTANCE OF PATIENTS

***a)*** **Registration of Doctors**

- Only doctors registered with the Malaysian Medical Foundation (MMC) will be able to participate in the PAL Scheme.

***b)*** **Nomination of Patients**

- Patient has to read and acknowledge the basic information on **Form A** and bring it to the doctor.
- Patient has to get an ID doctor to fill up **Form B (Application Form)** which has to be verified by both the patient and doctor.
- Patient fills up **Form C (Household Monthly Income)** and gets verification from the Department of Medical Social Work Officer.
- Patient gives consent to **Form D, Personal Data Protection Act.**
- Patient will submit all completed forms (A, B, C and D) as well as supporting documents to Hospital/ Department of Medical Social Work at the current hospital that he/she is receiving a treatment.
- Hospital/ Department of Medical Social Work will ensure that all the documents are filled up and the required supporting documents are attached.
- Form A, B, C and D must be submitted together with any other supporting documents to the MAF at the aforementioned address for processing within 30 days of receipt.
- **Do not use correction tape/liquid paper in the application form**

## TERMINATION OF SPONSORSHIP *(PENAMATAN PENAJAAN)*

The MAF holds the right to terminate sponsorship prematurely based on the doctor's decision to stop therapy due to the patient's:

- Poor compliance with treatment
- Deteriorating health

A doctor who makes a decision to stop a patient's therapy will have to write officially to the MAF providing reasons for the decision. All such terminations will be replaced with patients who are on the Waiting List.

## RESPONSIBILITIES OF THE MALAYSIAN AIDS FOUNDATION

In ensuring that the Scheme is successfully implemented, the MAF will take on the following responsibilities:

- Ensure that all patients' personal data is kept confidential.
- Ensure prompt delivery of medication.
- Provide doctors with the assurance that they will be informed one month before the end of the Phase as to whether sponsorship of their patients could be continued.

The MAF provides one ARV medication to each selected patient based on the knowledge that the Government provides the second ARV for free. It is hoped that the patient is able to purchase the third ARV to enable him/her to undergo the therapy.

# FORM/BORANG B

In Collaboration with:

**POSITIVE AUDACIOUS LIVING (PAL SCHEME)**
Medicine Assistance Scheme

**Application Form**
(To be filled by doctor)

## A. PATIENT'S PARTICULARS

Name : ________________________________________________

Age & Date of Birth : ________________________________________

IC / Passport No. : ______________________________________________

Address : ________________________________________________________

____________________________________Postcode : ________________

Telephone No. : ____________________

Heir's Telephone No. : ____________________

No. of Dependants (living in same household): _______

Patient's Relationship with Dependents: _______________________

Monthly Household Income: RM__________

## *B.* DOCTOR'S PARTICULARS

Name : ________________________________________________

Designation : __________________________________________________

Clinic/Department :

________________________________________

## FORM/BORANG B

Hospital : ______________________________________________________________

Address (office) :____________________________________________________________

________________________________________________Postcode :________________

Tel No. :_____________________Fax : _______________________

Email : ___________________________

## *C.* APPLICANT'S MEDICAL STATUS

Present CD 4 Count & Date Taken: __________________________________

Previous CD 4 Count & Date Taken: __________________________________

Present Viral Load Level & Date Taken __________________________________

Previous Viral Load Level & Date Taken __________________________________

Is the patient presently under any form of antiretroviral treatment? Please tick the appropriate box.

☐ Yes *(Ya)* ☐ No *(Tidak)*

If yes, please tick the appropriate box to indicate type of antiretroviral medication that patient is presently on. Please also state the drug dosage the patient is presently on as well as indicate how the patient is paying for each of his/her treatment (if it is government-sponsored, please also state).

# FORM/BORANG B

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Lamivudine (3TC) | NRTI | ______ | ______ |

Comment : ______

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Truvada (Tenvir-Em) | NRTI | ______ | ______ |

Comment : ______

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Zidovudine (AZT) | NRTI | ______ | ______ |

Comment : ______

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Crixivan (indinavir) | PI | ______ | ______ |
| ☐ | Saquinavir (invirase) | PI | ______ | ______ |
| ☐ | Ritonavir | PI | ______ | ______ |

Comment : ______

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Kaletra | PI | ______ | ______ |

Comment : ______

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Neveripine | NNRTI | ______ | ______ |

Comment : ______

| | Generic Name | Class | Dosage | Paid By |
|---|---|---|---|---|
| ☐ | Efavirenz (Stocrin) | NNRTI | ______ | ______ |

Does the patient have any life-threatening illness thereby reducing his/her life expectancy to less than 6 months? ☐ Yes ☐ No

Does the patient have any non-HIV terminaldiseases such as cancer and late stage liver diseases? ☐ Yes ☐ No

## *D.* TYPE OF ASSISTANCE REQUIRED

Please tick ONLY ONE (1) antiretroviral medication requested for patient.

| | Generic Name | Class | Dosage |
|---|---|---|---|
| ☐ | Crixivan (Indinavir) | PI | ________________ |
| ☐ | Saquinavir (Invirase) | PI | ________________ |
| ☐ | Kaletra | PI | ________________ |
| ☐ | Tenofovir/emtricitabine | NRTI | ________________ |
| ☐ | Ritonavir | PI | ________________ |
| ☐ | Raltegravir | Intergrase Inhibitors | ________________ |
| ☐ | Dolutegravir | Intergrase Inhibitors | ________________ |
| ☐ | Others *(lain-lain)* | ________________ | ________________ |

Reason for selection of/change to this ARV:

________________________________________________________________________________

AGREEMENT

We,_______________________________________________[name of the doctor] and

________________________________________________[name of the patient] hereby confirm

that all information provided herein is accurate to the best of our knowledge.

As the doctor responsible for this patient, I agree to undertake the responsibilities outlined in FORM A – Registration should my patient be accepted to take part in the MAF's PAL Scheme.

_______________________________ _______________________________
[Doctor's Signature] [Patient's Signature]

Date: _________________________

In Collaboration with:

FORM C/ BORANG C

**VERIFICATION FORM**
**HOUSEHOLD MONTHLY INCOME**
**FOR PAL SCHEME SPONSORSHIP CANDIDATES**

**INSTRUCTIONS:**

1. Please complete the form clearly
2. Please attach a photocopy of your Identification Card AND

Employed:

1. Latest KWSP statement or
2. Letter of employment from employer

Self-Employed:

1. Latest three months bank statement and
2. Supporting letter from Grade A Civil Servant (Doctor/JKKK/Medical Welfare Officer Grade 41 above)

## A. CANDIDATE'S INFORMATION *(MAKLUMAT CALON)*

1. Full Name : ______________________________
2. Identification Card No. : ______________________________
3. Address : ______________________________
______________________________
______________________________
4. Candidate Telephone No. : ______________________
5. Heir's Telephone No. : ______________________
6. Occupation : ______________________
7. Monthly Income : ______________________
8. *Email Address* :______________________

**B. DEPENDENT'S INFORMATION *(MAKLUMAT TANGGUNGAN KELUARGA)***

Children who are working or married and aged 21 years and above must be excluded. However, exceptions are made for children with disabilities or are completing their First Degree (undergraduate)studies.

| **No** | **Name** | **Age** | **Relationship** | **Name of institution (School/ College/ University/ etc)** | **Yearly Scholarship/ Sponsorship (If any)** ***RM*** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

*(Please add an extra sheet if the space above is insufficient.)*

## *C.* PATIENT'S CONSENT

I hereby declare that the details furnished above are true and correct to the best of my knowledge and belief. Furthermore, I authorize the Malaysian AIDS Foundation to run a background check with the appropriate agencies on my financial declaration. I also accept that, should any of the information given herein is found to be false, the Malaysian AIDS Foundation reserves the right to reject my application.

……………………………………… ……………………………………

Date Signature

## *D.* VERIFICATION (DOCTOR/ MEDICAL WELFARE OFFICER GRADE 41 ABOVE)

Comments *:*

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

____________________________

I hereby certify that the above information is true.

……………………………………… ………………………………………

Date Signature

Name *:*

IC Number :

Position *:*

Official Stamp :

**FORM D**
***(English Version)***

In Collaboration with:

**PERSONAL DATA PROTECTION ACT 2010 NOTIFICATION TO PAL SCHEME BENEFICIARIES UNDER MALAYSIAN AIDS FOUNDATION SPONSORSHIP**
**Collection, Recording, Storage and Retention of Personal Information**

The personal data that **Malaysian AIDS Foundation** ("**MAF**") has previously collected includes but is not limited to the information made available to us in the Application for Scholarship, Sponsorship Form, documentation relating to the beneficiaries, emails, phone calls, referrals and all other documentation submitted by you to us for purposes relevant or related to your scholarship/sponsorship, including, but not limited to your name, address, e-mail address, photograph, HIV status, birth date, phone numbers, identification card and/or passport number, race, gender, bank details, academic results, language and/or communication channel preferences (collectively, "**the personal information**").

Your personal information may be used for various purposes, including, but not limited to:-

- To administer and conduct assessment of your application to get sponsorship/scholarship from us
- To administer and conduct assessment of your application to get sponsorship/scholarship from other agencies whether from government or corporates bodies
- To better understand your needs
- To provide services to you
- To improve our products and services
- To process your payment transactions
- For administration purposes
- To conduct our activities
- For security and fraud prevention purposes
- For internal record keeping
- For statistical analysis
- For our branding, communications and corporate affairs purposes which include publication in MAF's printing materials, website and/or electronic media as well as external parties' printing materials and/or electronic media
- For the purpose of complying with the Companies Act 1965
- For the purposes of our corporate governance

(collectively, "**the Purposes**")

Beneficiaries living with HIV should not be required to disclose their HIV status to MAF. A person's HIV status is their personal information. It is not appropriate for MAF to share Beneficiaries HIV status without Beneficiaries' consent. Beneficiaries must also be provided with information to make informed decisions and understand the consequences of whether to share their status. MAF ensures that people living with HIV are supported to feel comfortable to disclose their status by having this confidentiality notification. This is to support disclosure and protect the right to confidentiality of people living with HIV. MAF ensures Beneficiaries are aware of the consequences of disclosure and are comfortable enough with their HIV status to be open. This is the key to making sure that the benefits of involvement are realised. It is important to recognise the transformative potential for people, organisations and communities of having people involved who are open about living with HIV in the workplace. This can help to challenge misconceptions and reduce HIV-related stigma, but can also come at a social cost to those who are open.

**FORM D**
***(English Version)***

As part of our policy, it is not only necessary but imperative that we continue to retain your personal information made available to us as well as collect, record, store and retain further and/or other personal information when required for any of the Purposes and/or for the purpose of fulfilling our obligations to you in respect of the Purposes and/or all such other purposes related to the Purposes and/or for purposes relevant or related to your scholarship/sponsorship (collectively, "**the Said Reasons**").

Please be informed that your personal information may be disclosed, disseminated and/or transferred within Malaysian AIDS Foundation(including its partner organizations, local and international donors), whether present or future (collectively, "**the Group**"), business partners or to any third party organisations or persons providing administration (including but not limited to cloud storage and maintenance of records) or other services to the Group or for the purpose of fulfilling our obligations to you in respect of the Purposes and all such other purposes that are related to the Purposes and also in providing other services to the Group or involved in any corporate exercises undertaken by the Group, within or outside Malaysia, for and in respect of the Said Reasons.

To this end, we are committed in ensuring the confidentiality, protection, security and accuracy of your personal information made available to us. In this regard, it is your obligation to ensure that all personal information submitted to us and retained by us are accurate, not misleading, updated and complete in all aspects. For the avoidance of doubt, we and/or the Group and/or its employees or authorized officers or agents will not be responsible for any personal information submitted by you to us that is inaccurate, misleading, incomplete and not updated.

Further, we also request your assistance to procure the consent of third parties whose personal data is made available by you to us and you hereby agree to use your best endeavours to do so.

You may submit your request for access to your personal data by submitting such request to us in writing to the address below in the event:

(a) you require access to and/or wish to make corrections to your personal data subject to compliance of such request for access or correction not being refused under the provisions of the Act and/or existing laws;

(b) you wish to enquire about your personal data; and

(c) you are no longer agreeable to us retaining, holding or storing your personal data. However, please note that this may result in us not being able to properly perform or discharge our obligations to you.

Malaysian AIDS Foundation
No. 12, Jalan 13/48A,
The Boulevard Shop Office,
Off Jalan Sentul, 51000 Kuala Lumpur
Tel: 03 4047 4222

Any personal information retained by us shall be destroyed and/or deleted from our records and system in accordance with our retention policy in the event such information is no longer required for the Said Reasons.

We trust that you will consent to the processing of your personal information, and that you have read, understood and accepted the statements and terms herein.

………………………..
Name of Beneficiaries:
IC Number:

In Collaboration with:

Acceptance Form

***FORM E***

**POSITIVE AUDACIOUS LIVING (PAL) SCHEME**

Medicine Assistance Scheme

**Patient Consent**

(To be filled by the nominated patient and Doktor)

I,________________________________________________[name of patient] of

______________________________[IC / Passport No.] hereby state the following:

1) I accept the offer to participate in the PAL Scheme between __________________ (date of commencement) and_______________(end date) and receive the sponsored medication on an alternate month basis.

2) I have read and understood the terms and conditions of the PAL Scheme as stipulated in FORM A and will endeavor to comply.

3) I expressly consent to my personal details and medical particulars being disclosed to the Malaysian AIDS Foundation for the purpose of this Scheme.

____________________________ ____________________________

[signature of patient] [date]

*FORM E*

I,______________________________________________________[name of Doctor] wish to confirm that the aforementioned is a patient under my care at _______________________________(name of hospital) who has accepted the offer to participate in the PAL Scheme.

____________________________ ____________________________
[signature of doctor] [date]

Witness Name: __________________________________________________

Witness IC / Passport No.: __________________________________________________

Witness Signature: __________________________________________________

Date: __________________________________________________

In Collaboration with:

Acknowledgement of Receipt of Medicine Form
FORM F

**POSITIVE AUDACIOUS LIVING (PAL SCHEME)**
Medicine Assistance Scheme

**Patient Consent**
(To be filled by the nominated patient and Doctor)

I,________________________________________________________[name of patient] of

_________________________[IC / Passport No.] hereby state the following:

I have received the medicine______________(name of medicine) sponsored by Malaysian AIDSFoundation for the month of_________on the date I signed this form.

___________________________ [signature of patient]

___________________________ [date]

FORM/ BORANG F

I,______________________________________________[name Doctor] hereby confirm that I have given medicine of this Scheme to the aforementioned patient and I am satisfied he / she understands the same.

______________________________ [signature of Doctor]

______________________________ [date]

Witness Name: ______________________________________

Witness IC / Passport No.: ______________________________

Witness Designation: __________________________________

Witness Signature: ___________________________________

Date: _____________________________________________

| **FOR MAF SECRETARIAT USE ONLY** | |
|---|---|
| Verified By:<br><br><br>Signature:<br>Name:<br>Designation:<br>Date: | Certified By:<br><br><br>Signature:<br>Name:<br>Designation:<br>Date: |

# FORM G

In Collaboration with:

**POSITIVE AUDACIOUS LIVING (PAL SCHEME)**
Medicine Assistance Scheme

**Updated Beneficiaries Medical Status Form**
(To be filled by doctor for every 6 months)

## A. BENEFICIARY'S PARTICULARS

Name :_______________________________________________________

Age & Date of Birth : ________________________________________

IC / Passport No. : _____________________________________________________

Address : ______________________________________________________________

__________________________________________Postcode : __________________

Telphone No. : _______________________

## B. DOCTOR'S PARTICULARS

Name : ________________________________________________________

Designation : ___________________________________________________________

Clinic/Department :

_____________________________________________

Hospital : _________________________________________________________

Address (office) :_______________________________________________________

_____________________________________________Postcode :______________

Tel :______________________Fax : _____________________

Email : _________________________

**FORM G**

## *C.* BENEFICIARY'S MEDICAL STATUS

Present CD 4 Count & Date Taken: ______________________________

Previous CD 4 Count & Date Taken: ______________________________

Present Viral Load Level & Date Taken ______________________________

Previous Viral Load Level & Date Taken ______________________________

Does the patient have any life-threatening illness thereby reducing his/her life expectancy to less than 6 months? ☐ Yes ☐ No

Does the patient have any non-HIV terminal diseases such as cancer and late stage liver diseases? ☐ Yes ☐ No

## *D.* Other Comments

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
__________________________

__________________________ __________________________
[Doctor's Signature] [Patient's Signature]

Date: __________________________