Annex 1 - Application for defrayal of costs

Information for emergency helpers (Nothelfer):
You treated a patient who does not have health insurance and therefore rendered assistance which would normally have been provided by the social welfare agency but which could not be provided by the latter due to lack of knowledge about the emergency situation. You are now applying as an emergency helper to the responsible social welfare agency for the reimbursement of your medical costs. The prerequisite for this reimbursement claim is that, with timely knowledge, the responsible social welfare agency would have rendered services in accordance with SGB XII (Book XII of the Social Code). For that very reason, therefore, the patient you treated ought to have had a claim to the service rendered. The burden of proof for this lies with you. To make it easier for you to provide proof of the obligation to render service on the part of the social welfare agency, we developed the enclosed questionnaire which seeks to obtain the same information that would also have been asked for by the social welfare agency during the personal interview with the patient before treatment. In your own interest, therefore, we request you to have this questionnaire filled in urgently with the express consent of the patient and to attach it to your application for reimbursement of costs in accordance with Section 25 of the SGB XII or Section 6(a) of the Asylum Seekers Benefits Act (AsylbLG), accompanied by supporting documents.

Information for patients:
You received medical treatment in the hospital and you do not have any health insurance. You must therefore bear the costs of your treatment yourself. In exceptional cases, however, your medical costs can be reimbursed to the hospital by the responsible social welfare agency, if you are entitled to social welfare or benefits in accordance with the Asylum Seekers Benefits Act. To enable us verify this, we request you to urgently fill in the enclosed questionnaire completely and sign it. Thereafter, the hospital that treated you without health insurance cover will submit the questionnaire together with their application for reimbursement of costs to the responsible social welfare agency in accordance with Section 25 of the SGB XII or Section 6(a) of the Asylum Seekers Benefits Act (AsylbLG).

Information for foreigners:
The persons mentioned in Section 203(1-3) of the Penal Code (e.g. a doctor, the hospital administration) are subject to the **confidentiality obligation** in accordance with Section 203 of the Penal Code (StGB). The social welfare agency may transmit your personal data to the Immigration Office within the context of verifying your claim in accordance with Section 25 of the SGB XII or Section 6(a) of the Asylum Seekers Benefits Act (AsylbLG). However, only the **name** and the **date of birth** will be transmitted.

Information provided by you within the context of asserting claims against the hospital in accordance with Section 25 of the SGB XII, and which must be transmitted by the hospital to the social welfare agency in connection with the settlement process, may not be used for measures pertaining to the Residence Act or the EU Freedom of Movement Act (so-called **extended social data protection**). The extended social privacy does not apply if you are eligible for benefits in accordance with the Asylum Seekers Benefits Act. In this case the Immigration Office may use your data which was transmitted by the social welfare agency also for measures pertaining to the Residence Act or the Freedom of Movement Act, if necessary.

Furthermore, data will be transmitted to the Immigration Office

for the purpose of averting considerable risk to the life and limb of the foreigner or third parties, and if the foreigner is a risk to public health and there are no possible special protective measures for averting the risk or the foreigner does not adhere to such measures (Section 88(2) no. 1 of the Residence Act)

or

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insofar as the data is required for determining whether the preconditions stipulated in Section 54(2) no.4 of the Residence Act exist (severe drug addiction and refusal of required rehabilitation measures), Section 88(2) no. 2 of the Residence Act.

The following Section 1 has to be filled in by the emergency helper.

1. Medical emergency

a) Description of the medical emergency, which comprises of diagnosis, required treatment and emergency certificate (has to be issued directly by the emergency helper, e.g. the hospital, and attached to their application).

b) Time of admission/ Duration of treatment

The following sections 2 to 13 have to be filled by the patient

2. Your personal data

Surname:

First name(s):

Name at birth:

Date of birth:

Place of birth:

Gender:

Nationality:

Marital status:

Address (also c/o):
or where applicable, habitual place of abode:

Where applicable, Home address:

Telephone (optional):

Please enclose a copy of your passport or any other suitable proof of identity (e.g. other official documents with a photo, like driving licence etc.).

☐ Copy is not possible because
Instead proof of identity can be provided as follows:

What is your **resident status**?
(Please enclose a copy of a supporting document as proof)

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Status/details of the residence permit or other certificate:

Valid until:

Issued by:

3. For minor patients: Particulars of the parents

Father:

Surname:

First name(s)

Date of birth:

Address:

Health insurance is held by:

Mother:

Surname:

First name(s)

Date of birth:

Address:

Health insurance is held by:

a) Do the **parents earn any income**?

☐ Yes – in what amount?: _____ Euros/month

This is income from:

☐ employment subject to social security contributions

☐ marginal employment (mini job)

☐ Self-employment

☐ Social benefits received (e.g. SGB II)

(Please enclose supporting documents as proof)

☐ No

If no, livelihood is earned as follows:

4. Details of income and assets

How do you earn your livelihood?

a) Do you have an **income**?

☐ Yes – in what amount?: _____ Euros/month

If yes: This is income from:

☐ Employment subject to social security contributions

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☐ Marginal employment (mini job)

☐Self-employment

☐ Social benefits received, and these are:

☐ Sustenance

☐ Other earnings (pension, rent, etc.)

☐ No
If no, livelihood is or was earned through (concrete list of how and where the livelihood is derived from, e.g. collecting bottles, selling all and sundry):

b) Do you own any **assets** in Germany or in another country (for foreigners in particular: in your home country)?

☐ No

☐ Yes – in what amount or of what value?

Cash:

Savings:

Property/real estate:

Car(s):

Other assets:

5. Culpability of third parties for the illness

Is **a third party culpable** for your illness (e.g. through a motor accident)?

☐ No

☐ Yes

If yes, please describe, in the case of an accident, the place and circumstances which led to the accident:

Please indicate the name and address of the third party or, if necessary, of the insurance company:

Is the **accident in connection with your job / gainful employment** (e.g. through an accident at work, while at school, or a travel-related accident)?

☐ No

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☐ Yes
If yes, please describe the place and circumstances which led to the accident:

Please indicate the name and address of the employer or of the school:

Please indicate the name and address of the accident insurance agency:

6. Personal health insurance

Are you or were you medically insured in Germany?

☐ **Yes:**

☐ statutory health insurance (where applicable, family insurance)

☐ private health insurance

Name and headquarters of the insurance company or health insurance scheme:

Till when were you insured?

☐ **No**

If no: I choose the following statutory health insurance scheme:

Are you or were you medically insured in your country of origin?

☐ Yes - Please indicate the name of the insurance company / headquarters / country of insurance

(A copy of a supporting document, e.g. a Foreign Health Insurance Card, **E**uropean **H**ealth **I**nsurance **C**ard (EHIC), Provisional Replacement Certificate (PEB) has to be enclosed as proof)

☐ No
(A copy of a supporting document concerning the non-existence of health insurance has to be enclosed as proof)

Till when were you insured?

Have you or had you taken out **travel health insurance** in your country of origin?

☐ Yes - Please indicate the name of the insurance company / headquarters / country of insurance
(Please enclose a copy of a supporting document as proof)

☐ No

7. Health insurance for spouse or life partner (if the civil partnership is considered to be equivalent to marriage in the home country)

Surname:

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Is or was he/she medically insured in Germany?

☐ Yes:

☐ statutory health insurance (where applicable, family insurance)

☐ private health insurance

Name and headquarters of the insurance company or health insurance scheme:
(Please enclose a copy of a supporting document as proof)

Till when was he/she insured?

☐ No

Is or was your spouse or life partner medically insured in the country of origin?

☐ Yes - Please indicate the name of the insurance company / headquarters / country of insurance

(A copy of a supporting document, e.g. a Foreign Health Insurance Card, **E**uropean **H**ealth **I**nsurance **C**ard (EHIC), Provisional Replacement Certificate (PEB) has to be enclosed as proof)

☐ No
(A copy of a supporting document concerning the non-existence of health insurance has to be enclosed as proof)

Has or had your spouse or life partner taken out travel health insurance in the country of origin?

☐ Yes - Please indicate the name of the insurance company / headquarters / country of insurance
(A copy of a supporting document has to be enclosed as proof)

☐ No

8. In case of pregnancy or childbirth

Child's father: Name, address, health insurance and nationality

Child's father is unknown ☐

9. Details of the travel to and stay in Germany

When did you enter Germany?

Since when have you been staying in Hamburg?

Where were you staying before your moved to Hamburg?

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Why did you come to Germany?

Did a third party submit an **undertaking** to the Immigration Office or the Diplomatic Mission before your travel **in accordance with Section 68 of the Residence Act**? (Did anybody in Germany want to take care of your livelihood?)

☐ No

☐ Yes - Name and address of the sponsor:
(if possible, please enclose a copy of the undertaking)

Are you ready to leave the country after medical treatment?

☐ No, reason:

☐ Yes

Note: If you are ready to leave the country after medical treatment, the departure must in principle take place not later than one month after the end of the medical treatment.

10. Details of the spouse or life partner of the patient:

☐ No spouse or life partner

Surname:

First name(s):

Name at birth:

Date of birth:

Place of birth:

Gender:

Nationality:

Current professional activity:

Marital status:

Address:
(also c/o)

Where applicable, Home address:

Telephone (optional):

Where applicable, Residence status:
(Please enclose a copy of a supporting document as proof)

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11. Details of the income of the spouse or life partner

Does your **spouse or life partner**, or (in the case of minor patients) do your **parents** earn **any income**?

☐ Yes – in what amount?: _____ Euros/month

This is income from:

☐ Employment subject to social security contributions

☐ Marginal employment (mini job)

☐ Self-employment

☐ Social benefits received
(Please enclose supporting documents as proof)

☐ No
If no, livelihood is earned through:

12. Details of the children of the patient

Children ☐ Yes ☐ No

If yes, please fill in the table:

	Child 1	**Child 2**	**Child 3**
Surname			
First name(s)			
Name at birth			
Date of birth			
Place of birth			
Gender			
Nationality			
Marital status			
Address (also c/o)			
Where applicable, Home address			
Telephone (optional)			
Where applicable, Resident status (please enclose a copy of a supporting document as proof)			

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Does the child or do the children have any income?

☐ Yes – in what amount?: _____ Euros/month

This is income from:

☐ Employment subject to social security contributions

☐ Marginal employment (mini job)

☐ Self-employment

☐ Social benefits received

If yes: Do the **parents receive sustenance support** (e.g. financial benefits, house)?
In what amount?

13. Support by other bodies

Have you engaged a **lawyer**? If yes, in which areas does he represent your affairs? Do you have any personal documents relating to this?

Surname:

Address:

Tel./FAX/Email:

Do you receive any advice and support from a **(migration) advisory centre**? Did you have any contact with a (migration) advisory centre in the past? Do you have any personal documents relating to this?

Surname:

Address:

Tel./FAX/Email:

Declaration by the patient:

I hereby confirm that the information contained in this questionnaire is true and correct.

I agree that my personal data may be transmitted to the social welfare agency in Hamburg and be processed by them for settlement purposes in connection with an application for defrayal of costs, and in this regard I accordingly release the doctor from his oath of secrecy.

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I request that the medical costs be assumed by the social welfare agency.

Date, place and signature of the patient