

ENHANCED UP HOSPITALIZATION PROGRAMME (UP eHOPE)

APPLICATION FORM			No.
Last Name	First name		Middle Initial
Position	Unit	Age	Civil Status:
Date of Filing	Name of Hospital	Total Amount Applied	Period of Hospitalization
Cause/Reason of Hospitalization:			
Recommended by:			
Employee's Signature	Unit Head/Administrative Officer <small>(Signature over Printed Name)</small>		Date
HRDO CLEARANCE			
Appointment Status: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary <input type="checkbox"/> Casual <input type="checkbox"/> UP Contractual <input type="checkbox"/> Co-term <input type="checkbox"/> Substitute (charged to GAA) <input type="checkbox"/> GAA <input type="checkbox"/> RF/TF. Pls. specify:			
Date of original appointment:		<input type="checkbox"/> Active Service	
Number of years in service:		Leave without Pay (LWOP)	
Date of last application: _____		<input type="checkbox"/> Deducted	
Application Count: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd Others: _____		<input type="checkbox"/> Not yet deducted	
UP eHOPE Account Balance: PhP _____ Medicine : PhP _____ as of _____			
Cleared by:			
p _____ HRDO Head <small>(Signature over Printed Name)</small>			Date
EVALUATION/VALIDATION/RECOMMENDATION of the HRDO [] eHOPE Committee [] [N.A.]			
Requirements			
<input type="checkbox"/> Medical Certificate from Attending Physician/s		<input type="checkbox"/> Original OR for Medicines/Laboratory Tests	
<input type="checkbox"/> Summary Statement of Accounts showing PhilHealth and other health insurance deductions		<input type="checkbox"/> Surgical Technique (for surgical cases)	
<input type="checkbox"/> Original Official Receipt (OR) of Hospital Bill		<input type="checkbox"/> Discharge Order/Copy of Going Home Instruction, if any	
<input type="checkbox"/> Other requirements: please specify: _____			
ACTION of the [] HRDO [] eHOPE Committee [N.A.]			
<input type="checkbox"/> Approved <input type="checkbox"/> Disapproved		Approved Amount:	Payable to:
Remarks: _____ eHOPE Committee : _____		PhP	
		PhP	
HRDO Head / eHOPE Committee Chair <small>(Signature over Printed Name)</small>		Date	
		PhP	
Budget Clearance			
Amount: PhP _____		Cleared by: _____ Date: _____	
Budget Director/Head <small>(Signature over Printed Name)</small>			
Recommending Approval:		Approved by:	
_____ Vice Chancellor for Administration and Finance <small>(Signature over Printed Name)</small>		_____ Chancellor <small>(Signature over Printed Name)</small>	
Date: _____		Date: _____	

UP Manila eHOPE Itemized Breakdown of Expenses

Date: _____

Name of Employee		
Nature/Name of Illness		
Period of Confinement		
Name of Hospital Confided		
<u>Itemized Breakdown of Expenses:</u>		
HOSPITAL BILL		
	<u>Charge to HHI</u>	<u>Charge to eHOPE</u>
Philippine General Hospital	₱	₱
Other Hospital (Name of Hospital)	₱	₱
PROFESSIONAL FEE		
Name of Doctor/s	<u>Charge to eHOPE</u>	<u>Paid PF/Reimbursable</u>
	₱	₱
	₱	₱
	₱	₱
	₱	₱
DIAGNOSIS PROCEDURE (NET OF DISCOUNT)		
Date of Procedure	Amount	
	₱	
	₱	
		₱
OTHERS: (EQUIPMENT RENTAL, ETC.)		
	₱	
	₱	
		₱
DRUGS AND MEDICINES		
<i>not included in the hospital bill/or was bought outside of the hospital (net of discount, attach extra sheet if needed)</i>		
Date and Drugstore	O.R. No.	Amount
		₱
		₱
		₱
Total Amount Reimbursable		₱
Total Amount Charge to eHOPE		₱

I do hereby certify that the official itemized breakdown of medical expenses for laboratory examinations, surgery, or any other medical procedure and medicines used during the period of confinement is true and correct. The amount of reimbursement due is net of the medical expenses covered by PhilHealth and other private health card benefits.

Note: As per policy, a maximum of ₱100,000 per year per qualified employee is allotted to eHOPE.

(Signature of Employees)

INSTRUCTIONS:

- The eHOPE program provides financial assistance for hospitalization expenses incurred during confinement for faculty, REPs, and administrative staff. It shall also provide financial assistance for medicines related to the covered confinement and prescribed drugs upon discharge of the employee. A maximum of P100,000.00 per year per employee is allotted to this benefit.
- Eligible employees for financial assistance under eHOPE shall be the following: [1380th BOR Meeting, April 27, 2023; Memorandum No. PAJ 23-21, 29 June 2023]
 - Regular permanent full-time and part-time faculty members;
 - Regular full-time faculty members who are not tenured provided they have rendered at least one (1) year of continuous service in the University;
 - Permanent REPS and administrative staff;
 - UP contractual and casual employees (including faculty, REPS, and administrative staff) who have rendered at least one (1) year of continuous service to the University, have employer-employee relations with the University, and whose salaries are paid out of the Personnel Services (PS) allocations to UP in the General Appropriations Act (GAA);
 - UP contractual and casual employees (including faculty, REPS, and administrative staff) who have rendered at least one year of continuous service to the University, have an employer-employee relationship with the University, and whose salaries are charged against the Revolving Fund (RF) or trust fund (TF)**

3. Eligible claimants must be in active service in UP at the time of the claim. Part-time faculty members shall be entitled to reduced benefits in proportion to the extent of their service to the University.

4. Sample Form (Application form)

CU: _____ Manila

ENHANCED UP HOSPITALIZATION PROGRAMME (UP eHOPE)

APPLICATION FORM				No.
A. Last Name Reyes		B. First name Maria Josephine		C. Middle Initial A.
D. Position Administrative Office I		E. Unit CAD-HRDO	F. Age 30	G. Civil Status: Married
H. Date of Filing 7/3/2023	I. Name of Hospital PGH	J. Total Amount Applied 34,252.00	K. Period of Hospitalization June 7-8, 2023	
Cause/Reason of Hospitalization: L. maternal delivery				
M. Employee's Signature <i>Maria Josephine A. Reyes</i>		N. Recommended by: <i>Juan R. Dela Cruz</i> Unit Head/Administrative Officer (Signature over Printed Name)		O. Date 4 June 2023

5. Sample form (UP Manila eHOPE Itemized Breakdown of Expenses)

UP Manila eHOPE Itemized Breakdown of Expenses

Date: 3 June 2023

Name of Employee	Maria Josephine A. Reyes	
Nature/Name of illness	Maternal Delivery	
Period of Confinement	June 7-8, 2023	
Name of Hospital Confided	PGH	
Itemized Breakdown of Expenses:		
HOSPITAL BILL		
	Charge to HHI	Charge to eHOPE
Philippine General Hospital	P	P 24,252
Other Hospital (Name of Hospital)	P	P
PROFESSIONAL FEE		
Name of Doctor/s	Charge to eHOPE	Paid PF/Reimbursable
Dr. Rosario	P	P 10,000
	P	P
	P	P
	P	P
DIAGNOSIS PROCEDURE (NET OF DISCOUNT)		
Date of Procedure	Amount	
	P	
	P	
		P
OTHERS: (EQUIPMENT RENTAL, ETC.)		
	P	
	P	
		P
DRUGS AND MEDICINES <small>not included in the hospital bill/or was bought outside of the hospital (net of discount, attach extra sheet if needed)</small>		
Date and Drugstore	O.R. No.	Amount
		P
		P
		P
		P
Total Amount Reimbursable		P 34,252.00
Total Amount Charge to eHOPE		P 34,252.00

I do hereby certify that the official itemized breakdown of medical expenses for laboratory examinations, surgery, or any other medical procedure and medicines used during the period of confinement is true and correct. The amount of reimbursement due is net of the medical expenses covered by PhilHealth and other private health card benefits.

Juan R. Dela Cruz
(Signature of Employees)

Note: As per policy, a maximum of P100,000 per year per qualified employee is allotted to eHOPE.

6. The following document shall be attached together with the duly completed form upon application: **No Complete documents, No Processing.**

- Duly accomplished eHOPE Itemized Breakdown of Expenses
- Medical Certificate from Attending Physician/s
- Summary Statements of Accounts showing Philhealth and other health insurance deductions.
- Original Official Receipts (OR) of Hospital Bill
- Original OR for Medicines/Laboratory Tests
- Surgical Technique (for surgical cases)
- Discharge Order/Copy of Going Home Instructions, if any