****

**TYPE OFFINANCIAL ASSISTANCE : MEDICAL**

***FAMILY HEAD’S DETAILS :***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **REGISTRATION NO.** | |  | | | | **ADHAR No. :** | | | | | | |  | | | | | | | |
| **NAME** | |  | | | |  | | | | | | | | | |  | | | | |
|  | | **Surname** | | | | **Name** | | | | | | | | | | **Middle** | | | | |
| **EDUCATION** | |  | | | | **OCCUPATION** | | | | | | | | | | **SERVICE / BUSINESS** | | | | |
| **TEL CONTACT** | | STD Code |  | | Phone | | | |  | | | | | | | | Mob. | |  | |
| **E-Mail** | |  | | | | | | | | | | | | | | | | | | |
| **NATIVE PLACE** | |  | | | | Caste | | | | | | | | | | | |  | | |
| **FAMILY DETAILS** | | **Members in Family** | | |  | Yearly Family Income | | | | | | | | | | | |  | | |
| Sr. | First Name | Middle Name | | Relation | | | Birth Date | | | | | | | | Profession | | | | | Annual Income |
| 1 |  |  | | SELF | | |  |  | |  |  |  | |  |  | | | | |  |
| 2 |  |  | | WIFE/HUSBAND | | |  |  | |  |  |  | |  |  | | | | |  |
| 3 |  |  | | SON/DAUGHTER | | |  |  | |  |  |  | |  |  | | | | |  |
| 4 |  |  | | SON/DAUGHTER | | |  |  | |  |  |  | |  |  | | | | |  |
| 5 |  |  | | SON/DAUGHTER | | |  |  | |  |  |  | |  |  | | | | |  |

***BANK DETAILS OF FAMILY HEAD:***

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME OF A/C HOLDER/S** |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ACCOUNT No.** |  |  | |  |  | |  | |  |  | |  |  | |  | |  |  | |  |  |  | |  |  | |  | |
| **NAME OF BANK** |  | | | | | | | | | | | | | | **BRANCH** | | | | |  | | | | | | | |
| **CITY/TOWN** |  | | | | | | | | | | | | | | **STATE** | | | | |  | | | | | | | |
| **BANK’S IFSC CODE** |  | |  | | |  | |  | | |  | | |  | |  | | |  | |  | |  | | |  | |

**Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Parent X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***RECOMMENDATION:***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **NAME OF RECOMMENDER MANDAL** | | |  | | | | |
| **ADDRESS OF MANDAL** | | |  | | | | |
| **TEL CONTACT** | STD Code |  | | Phone |  | Mob |  |

* **I know the above applicant PATIENT/ PARENT since last \_\_\_\_\_\_ years.**
* **To the best of my knowledge the details given in application is true and I recommend for the due relief.**

**Sign of Recommender (with seal):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***DETAILS OF PATIENT :*** | | | |  | | |  | | | | | | | | | | | |
| **ADHAR No.** |  | | | | | DoB | | d | | d | | m | m | | y | y | y | y | |
| **NAME** |  | | |  | | | | | | |  | | | | | | | |
|  | **Surname** | | | **Name** | | | | | | | **Middle** | | | | | | | |
| **RELATION WITH APPLICANT** | | | |  | | | | | | | | | | | | | | |
| ***HOSPITAL’S DETAILS :*** | | | |  | | |  | | | | | | | | | | | |
| **NAME OF HOSPITAL** |  | | | | | | | | **REG No** | | | | |  | | | | |
| **ADDRESS OF HOSPITAL** |  | | | | | | | | **ATTENDING DOTOR’S NAME** | | | | | | | | | |
|  | | | | | | | | | |
| **TEL CONTACT** | STD Code |  | Phone | |  | | | | Mob | | | | |  | | | | |
| **E-Mail** |  | | | | | | | | | | | | | | | | | |

***DISEASE / ILLNESS RELATED TO :[ Please (√) ]***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **BRAIN** |  |  | **ENT** |  |  | **EYE / CATARACT/GLAUCOMA** |
|  | **CARDIAC / HEART** |  |  | **LIVER** |  |  | **DIALYSIS / KIDNEY** |
|  | **JAUNDICE/TYPHOID/MALARIA** |  |  | **ORTHOPADIC** |  |  | **OTHER** |
|  | **CANCER** |  |  |  |  |  |  |

***HOSPITAL EXPENSES : HOSPITAL STAY :***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Room Charges** |  |  | **Admission Date** |  |
| **Operation Charges** |  |  | **Discharge Date** |  |
| **Doctor’s Fee** |  |  | **Total Days in Hospital** |  |
| **Pathology Charges** |  |  | **Have Medical Policy** | **Yes / No** |
| **X-ray / Scanning Charges** |  |  | **Original Discharge Card Attached** | **Yes / No** |
| **Medicine** |  |  | **Total Medical Expenses** | **Rs.** |
| **Other / Misc Charges** |  |  | **Amount of Claim** | **Rs.** |
| **Total Hospital Bill** |  |  | **Any help of any Trust / Person** | **Yes / No** |

**SUBMIT :**

1. **Xerox Copy of Patient’s & Applicant’s Adhar Card or its Application is Mandatory / Compulsory.**
2. **Cancelled (CTS- 2010 compliant) cheque& first page of Parent’s Bank’s pass book - Compulsory.**
3. **Xerox Copy of only Hospital Bill & Discharge Card is Compulsory. (No Medicine Bills)**
4. **The recommendation by Local KapolMandal of Applicant’s area is Mandatory / Compulsory.**
5. **All fields are Mandatory / Compulsory.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR OFFICE USE OF TRUST**

**APPLICATION : REJECTED FOR - INCOMPLETE FORM / INFORMATION / NON RECOMMENDATION**

**: BY PRESIDENT / V. PRESIDENT / SECRETARY – TRUSTEE on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Sr. No** | **Expense Head** | **Mode** | **Amount Sanctioned** | **Sign.** | **Amount Disbursed** | **Date of Disbursement** | **PAID BY NEFT Chq. No.** |
| **01** | **E6 –** |  |  |  |  |  |  |
| **02** | **E6–** |  |  |  |  |  |  |
|  |  | **TOTAL** |  |  |  |  |  |