APPLICATION FORM FOR FINANCIAL AID

1. Name & age of patient:

2. Father/Husband`s name:

3. Residential Address(Attach-photocopy of the relevant documents) BRING ORIGINAL documents at the time of submission of application.

PHOTOGRAPH OF PATIENT ATTESTED BY HOSPITAL`S MEDICAL SUPREINTENDENT/ TREATING DOC/CONSULTANT

4. Name of disease, since when suffering & treatment Required

5. Name of the hospital from where taking treatment. (attach a copy of O.P.D slip)

6. Financial assistance required
Estimate certificate certified by HOD & Med.Suptd. to be attached in ORIGINAL.

7. Two passport size photographs of the patients duly attested by M.S/Treating doctor /Consultant be enclosed out of which one should be pasted on estimate certificate and the other on this application form.

8. Whether the applicant has taken such assistance from any other sources ,if so, give details.

9. Whether the applicant has taken the assistance from Delhi Arogya Nidhi/Kosh earlier also, if so, details thereof..

It is certified that the information furnished above is true to the best of my knowledge & belief and that I am in no position at all to arrange for/provide funds for the purpose stated above.

SIGNATURE OF THE APPLICANT/PATIENT
Mob. No.

(Please bring Original Documents at the time of submission of application)

UNDERTAKING

I,_____s/o,d/o,w/o_____r/o_____ _____do hereby solemnly affirm and declare as under :-

1. That I / my wife / husband / son /daughter namely _____ has been suffering with _____ disease and is under treatment at _____ hospital for which the approximate expenditure shall be to the tune of Rs. _____ as certified by the hospital authorities.

2. That my total family income is Rs. _____ (Rs._____) per month. The source of income is by way of _____ (Give specific details).

3. That the details of members in National Food Security Card is as under:

S.	Name & Age	Relation	Profession	Income per month
1				
2				
3				
4				
5				
6				

4. That I am not in a position to bear the expenses of the treatment and am applying to Delhi Arogya Nidhi/Kosh for financial assistance.

5. That I know that to make a false statement is an offence punishable under relevant Act and law and whatever is stated above is true to the best of my knowledge and belief.

DEPONENT

VERIFICATION :-

Verified at New Delhi on this ……. day of …….. 2015 and that the contents of this affidavit are true and correct to the best of my knowledge and belief.

DEPONENT

WITNESSES:-

S No. Name & Address Signature

1.

2.

(In case patient is a minor, the deponent would be father, in case patient is housewife deponent would be husband, in case patient is adult and self dependent he/she would be deponent.)

ESTIMATE CERTIFICATE IN R/O PATIENTS SEEKING FINANCIAL ASSISTANCE FROM DELHI AROGYA KOSH/NIDHI

1.Name & Age of patient :

2.Name of Hospital :

3.OPD/Regd. No :

4.Father/Husband's Name :

5.Address :

6.Diagnosis :

PHOTOGRAPH OF PATIENT ATTESTED BY HOSPITAL`S MEDICAL SUPREINTENDENT/ TREATING DOC/CONSULTANT

7.Financial Assistance required:

(a) In case an operation is planned, the

Details of operation to be carried out

Expenditure likely to be incurred:

(b) In case patient is undergoing a cyclical treatment

Like chemotherapy etc., the total expenditure per

Month or expenditure per cycle be given and details

Of items on which expenditure is to be incurred:

(c) Details of any other expenditure:

Signature of treating Doctor

Signature of Head of the Deptt.

*It is certified that particulars given are true to the best of my knowledge.

*It is further certified that the utilization certificate of grants released, if any, shall be submitted soon after the treatment is over.

Signature of the Medical Superintendent

of the Hospital/Medical Institution with Official Seal

NB: The estimate form should be filled by the treating doctor.