APPLICATION FORM FOR FINANCIAL ASSISTANCE

(Please tick mark (√)

RASHTRIYA AROGYA NIDHI (RAN)		HEALTH MINISTER'S DISCRETIONARY GRANT(HMDG)	

1. Name of the Patient (in Block Letters) _____
2. Age _____
3. (a)Permanent Address along with Pin Code of the area _____
   (b) Address for Correspondence _____
4. Father's/ Husband's Name _____
5. Applicant's Relationship with the Patient _____
6. Disease from which suffering (Name of the disease) _____
7. Whether the applicant or the Person on whom He/ She depend is an Employee of Centre/State Govt. /pensioner _____
8. Monthly Income and Occupation of the applicant and his family members from all sources with complete address of the Employer. (An Income Certificate from the BDO/Tehsildar certifying that the beneficiary belongs to a BPL category or if the applicant employed, a certificate from the Employer regarding Income, must be attached in Original) _____
9. Quantum of Financial Assistance Required _____
10. Whether financial assistance for the same purpose (i) has been received (ii) a request has been/is being made to some Department/Agency/Authority other than Ministry of Health & Family Welfare, if so, Give Full Particulars _____
11. Attach a copy of the Ration Card duly attested by a Gazetted Officer with official seal, if applying for financial assistance under RAN. _____

DECLARATION

I declare that the information given above is correct and complete in all respect.

Dated:

Signature of the Applicant/ Patient

TO BE FILLED BY THE M.O INCHARGE OF THE CASE/ HOSPITAL ETC. WHERE THE PATIENT RECEIVING THE TREATMENT

1. Patient's Name & Hospital Registration Number _____

2. List of Report of important investigation done _____

3. Diagnosis :
A short note on the present clinical condition may be given _____

4. If the patient has been operated, date of operation. _____

5. Is the patient Hospitalized? If so, the name of the Hospital. Whether Hospital is Govt. / Private _____

6. The amount of money recommended for treatment _____

7. Item wise Break-up of expenditure of amount recommended at Col. No. 6 _____

Name of the consumables/ medicines required for operation/ treatment	**Cost in Rupees**
(A)	
(B)	
(C)	

Signature of the HOD/M.O In charge (Not Below the level of Consultant/ Asstt. Professor) with Official Seal

Certified that the patient's Particulars given above are true of the best of my knowledge and Belief.

Signature of the Medical Superintendent of the Hospital/ Medical institution with Official Seal