APPLICATION FORM FOR FINANCIAL AID

Photograph of Patient attested by hospital's Medical Suptdt.

1. Name & age of the patient :

2. Father/Husband's Name :

3. Residential address (Attach-photocopy of The relevant document (in case of minor birth certificate)& bring ORIGINAL of these documents at the time of submission of application-proof of domicile for last 3 years. :

4. Name of disease, since when suffering & treatment required :

5. Name of the hospital from where taking treatment. (Attach a copy of OPD slip) :

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

7. Monthly income certificate in ORIGINAL of family from all sources issued by S.D.M. or any other officer authorized in this behalf by the Revenue Department in the area under his jurisdiction

8. Two passport size photographs of the patient 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. :

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

10. 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. I also declare that neither my parents nor I are employees of the Central / State Govt. or a local body.

Signature of the applicant/patient

(In case patient is a minor, sign of father, in case patient is housewife, sign of husband, in case patient is adult and self dependent his/her signature. In case patient is adult and dependent on the income of father, signature of father, an affidavit would be required to be enclosed from the father that the patient is dependent on him)

Estimate Certificate in r/o patients seeking financial assistance from DELHI AROGYA NIDHI / KOSH

Photograph of Patient attested by hospital's Medical Suptdt. and his seal

1. **Name & Age of patient :**
2. **Name of Hospital :**
3. **OPD # / Regn. No. :**
4. **Father/Husband's Name :**
5. **Address :**
6. **Diagnosis of disease :**
7. **Financial Assistance required: Rs.**

   (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 or dialysis etc., the total expenditure per month or expenditure per cycle / per dialysis to 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 above 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.

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 my spouse and children whose age is upto 21 yrs is as below:

S.	# Name & Age	Relation	Profession	Income per month
1				
2				
3				

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.

VERIFICATION :- DEPONENT

Verified at New Delhi on this ..... day of ..... 20 and that the contents of this affidavit are true and correct to the best of my knowledge and belief.

WITNESSES:- DEPONENT

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.)