# APPLICATION FOR FINANCIAL ASSISTANCE OUT OF HEALTH MINISTER'S DISCRETIONARY GRANT

1. Name of the patient (in block letters) : _____
2. Age : _____
3. a) permanent address : _____
   _____
   b) Address for correspondence : _____
   _____
4. Father's / husband's name : _____
5. Whether the applicant or the person on whom he/she depends is an employee of the central/state Govt. : _____
6. Occupation and monthly income of the applicant and his family, with full address of the employer. A certificate from the BDO/Tehsildar or if the applicant is employed. Certificate from the employer regarding income must be attached in Original : _____
7. Source of livelihood if information in column no. 6 is nil. : _____
8. Quantum of financial assistance required. : _____
9. Whether financial assistance has been received from pr denied by the M/o Health & F. W. in the past, if so, give full details. : _____
10. Itrem-wise breakup of nexpenditure for which financial assistance has been applied for alongwith justification. : _____
11. Whetheer financial assistance for the same purpose (i) has been received from (ii)a request has been /is being made to some Deptt./agency/authority other than the M/o health & F. W., if so, give full particulars. : _____
12. Any other information. : _____

## DECLARATION

I declare that the information given above is correct and complete in all respect and that I am in no position at all to arrange for/provide funds for the purpose stated above. I also declare that neither I nor my parents are employees of the Central /State Government or a local body.

Dated: Signature of the applicant/patient

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

1. Patient's name & hospital registration number : _____

2. A short note on the present clinical condition of the patient : _____

3. List of report of important investigation done : _____

4. **DIAGNOSIS:**

   a) Basic illnes : _____

   b) Complication : _____

   c) Associated illness : _____

5. Is the patient hospitalised ? If so, where? : _____

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

7. Name of the hospital and Consultant /Doctors who have treated the patient. : _____

   a)

   b)

   c)

8. The amount of money recommended : _____

9. Itemwise break-up of expenditure of amount recommended at column No. 8

Name of the consumables/medicines required for operation/ treatment

Cost in Rupees

a)

b)

c)

Signature of the M.O. Incharge of the
Hospital/ Med. Institution with Office Seal.

Certified that the patient's particulars given above are true to the best of my knowledge and belief.

Signature of the M.O. Incharge of the