APPLICATION FOR FINANCIAL ASSISTANCE

(Please tick mark (✓)

RASHTRIYA AROGYA NIDHI (RAN)		HEALTH MINISTER'S DISCRETIONARY GRANTS	

1	Name of the Patient (in Block Letters)	
2	Age	
3	(a) Permanent Address along with Pin Code	
	(b) Address for correspondence	
4	**(a) Email Address (if available)**	
	(b) Mobile No. (if available)	
5	**(a) Father's /Mother's Name**	
	(b) Husband/wife's name	
6	Applicant's Relationship with the Patient	
7	Disease from which suffering (Name of the disease)	
8	Whether the applicant or the person on whom the patient is dependent, is an employee of Centre/State Government /Pensioner	
9	Monthly Income of the applicant and all family members from all sources issued by Tehsildar/BDO/SDO/ SDM/DC. **(Attested copy of Income Certificate should be attached. However, where online certificates are issued, self attested copy of income certificate may be enclosed)**	
10	Amount of Financial Assistance required	
11	Whether financial assistance has been received from (a) any Ministry/Department other than Min of Health & Family Welfare for treatment of the same disease. (b) Ministry of Health & Family Welfare earlier. If so, full details may be given.	
12	**Attach self attested copy of the Ration Card**	
13	**Aadhar Card No., if any (Attach self attested copy)**	

DECLARATION

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

Signature of the Applicant/Patient

Date :

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

1. Name of the Patient & Hospital Registration No. ____________________

2. Gist of Reports of important Investigations done ____________________

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3. Diagnosis-A short Note on the present clinical condition may be indicated ____________________

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4. If the patient has been operated, please Indicate the date of operation ____________________

5.(a)The name of the Hospital where the patient is receiving treatment. ____________________

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(b) Whether Hospital is Government or Private. ____________________

6. Amount recommended for treatment ____________________

7. Probable date of operation/intervention ____________________

8. Item wise break up of expenditure recommended in Column 6

Name of consumables/medicines required for operation/treatment	Cost (In Rupees)
1.	
2.	
3.	
4.	
5.	

Signature of the HOD/MO-in-charge
(Note below the level of Consultant/Assistant Professor with Official Seal

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

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