

**APPLICATION FORM FOR TREATMENT ASSISTANCE FROM
CHIEF MINISTER'S RELIEF FUND.**

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**(Application should be made during the treatment or maximum within three months
from the date of discharge from the empanelled hospital)**

1. (a) Name of the Patient. :
- (b) Son/Daughter/Wife of :
2. Age. :
3. Address
- AT : P.O.:
- Block : Tahasil:
- District: PIN :
- Mobile. No. :
- (Attach the photocopy of the Voter Card/ Aadhar Card)
4. Name of the applicant, if the application is not made by the patient. :
- (Attach the photocopy of the Voter Card/ Aadhar Card)
5. Applicant's Relationship with the patient. :
6. Annual Income of the family. (Attach e- Income Certificate issued by the Tahasildar) :
7. Disease from which suffering :
8. Name of the Hospital where the treatment is being received. :
- (a) Date of Admission :
- (b) Date of Discharge :
- (Attach photocopy of Discharge summary issued by the hospital)
9. Whether the patient/patient's spouse/patient's parents is/are employee/s (State Govt./Central Govt./PSU) : Yes No
(Please put (✓) Mark)
10. Whether the patient is a BSKY Card /Ration Card Holder(NFSA/SFSA) : Yes No
(Please put (✓) Mark)
- If yes, Please specify why the cashless treatment benefit was not availed under BSKY :

11. Whether Financial Assistance for the same :
Purpose has been received from the following.

- (a) BSKY/ CMRF/ PMNRF
- (b) Collector / Municipal Commissioner/ Sub – Collector
- (c) Health Insurance

If yes, specify the amount and date of sanction:

12. Checklist(Please tick (✓) the documents submitted)

Enclose the following documents.

- (a) Photocopy of Discharge Summary
- (b) Final Bills of expenditure in Original
- (c) e-income Certificate
- (d) Photocopy of Voter ID Card/ Aadhar Card
- (e) Photocopy of Organ Donation Permission Letter
(Mandatory in Organ Transplantation Cases)

DECLARATION

I _____ son/daughter/wife of
_____ hereby declare that, the information given above is correct
and complete in all respects. I also declare that neither I nor my parents nor my spouse are
employee of the Central / State Government / local body / PSU.

**NB: In case it is detected subsequently that, any fraudulent or misleading information has
been furnished by me, I shall be liable for legal action as deemed proper by the authorities.**

Place:

Signature of the applicant / patient

Date of submission
of application:

Mobile No:

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the empanelled hospital.**

Recommendation of Hon'ble MP/MLA

TO BE FILLD BY THE TREATING PHYSICIAN OF THE CASE/HOSPITAL ETC.
WHERE THE PATIET IS RECEIVING/HAS RECEIVED THE TREATMENT

1. Patient's Name :
2. Name of the Hospital :
3. Indoor Registration Number and date of admission :
- A short note on the present clinical condition of the patient :
4. Important Investigations Done. :
5. Diagnosis :
6. Details of treatment
Indicate date and other details :
 - (a) Medicine Management, ICU :
 - (b) Surgery :
 - (c) Chemotherapy :
 - (d) Haemodialysis :
 - (e) Others :
7. Amount of expenditure.
 - (a) Cost of important investigations :
 - (b) Cost of Surgery :
 - (c) Cost of Medicine, etc :
 - (d) Hospital Charges :
8. Whether the patient is assisted under BSKY/Health Insurance.If Yes, the quantum of assistance provided/ If no, the reasons thereof. :

Recommended By

Approved By

Signature of the Treating Doctors
with Official Seal

Signature of the Medical Superintendent
In-charge of the Hospital with Official Seal