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

***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:

Date of submission of application:

Signature of the applicant / patient

*__Mobile No:__

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

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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