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. Item-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