भवानी सेवा ट्रस्ट

Affix Passport Size colored photograph

MEDICAL ASSISTANCE APPLICATION FORM

(Please use BLOCK LETTERS (capital letters) for filling the application form)

A. PERSONAL DETAILS OF APPLICANT AND/OR PATIENT

1. Name of the applicant Mr./Mrs./Ms.:

First Name Middle Name Surname

2. Name of the Patient Mr./Mrs./Ms./Master (If other than applicant):

First Name Middle Name Surname

3. Age: Years Months

4. Sex (Tick √) Male Female

5. Patient PAN CARD No (If Available)

6. Patient's Aadhar No:

7. Applicants Aadhar No (If Patient and applicant is different)

8. Patient's relationship to the applicant:

9. Correspondence address of the applicant:

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10. Contact no of the applicant:

Mobile Phone	
Residence	
Office	

11. Email:

12. Permanent address (Leave blank if same as Correspondence Address):

B. TREATMENT DETAILS

13. Are you currently hospitalized: (Tick √)

☐ Yes ☐ No

14. Name of the Hospital:

15. Address of the hospital:

16. Ailment:

17. Is the disease life threatening? (Tick √)

☐ Yes ☐ No

18. Doctors name under which the treatment is going on:

19. Treatment:

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20. Total cost of treatment (estimated) (In Rs.) (To be certified by the Hospital administration on hospital's letter head and attached with the application form):

21. Family/Personal contribution (In Rs.):

22. Borrowed from relatives & friends (In Rs.):

23. Mediclaim eligibility from insurance company including private and Government (In Rs.):

24. Medical reimbursement amount from Employer (In Rs.): (On employer letter head- to be attached with application form)

25. Have you and / or any of your family members ever applied to the "**Bhawani Sewa Trust"** for medical assistance? Yes / No

If yes, please give details: _____

26. Total family income -(In Rs.):
(father/mother/husband/wife/son/daughter/sister/brother)

							PER MONTH	PER ANNUM

27. NEFT/RTGS details of the hospital:

_____

_____

28. Family Details*:

Sr. No.	Name of Family Members	Relationship to patient	Age	Occupation	Monthly Income
1.					
2.					
3.					
4.					

* If you don't have space in the above table, please add the details in an additional sheet.

29. Please give details regarding **financial assistance** sought from **other trusts / organizations*:**

Sr. No	Name of trust / organization	Applied on	Amount sanctioned or to be considered / OR refused, pending, any other
1.			
2.			
3.			
4.			
5.			

* If you don't have space in the above table, please add the details in an additional sheet.

30. Whether the patient is eligible for any Govt of India/State Government health insurance scheme like "***Pradhan Mantri Jan Arogya Yojana (PM-JAY), The Employees' State Insurance Scheme (ESI), The Mahatma Jyotiba Phule Jan Arogya Yojana, The Bhamashah Swasthya Bima Yojana, The Rashtriya Swasthya Bima Yojana (RSBY)" etc***. If yes; then reason for not availing the benefits under the above scheme:

_____

_____

31. Any other information which applicants/patient would like to share: -

_____

_____

32. I declare that the above facts stated/mentioned, and particulars given by me are true and correct.

Date Signature of the applicant Signature of the patient

Application received on:
(This field should be filled by TRUST)

Note: In case of thumb impression, please get it attested by the authorized person.

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INSTRUCTIONS

1. This medical assistance is for Indian citizens residing in India only.
2. Applications for the Medical assistance should be submitted either by the patient or by the patient's immediate family member (father/mother/husband/wife /son/daughter/sister/brother).
3. The applicant for the medical assistance should be above **11** years of age.
4. Please note that, application / medical assistance form received after the patient is discharged from the hospital will not be entertained or accepted by the Trust.
5. Incomplete forms will be rejected, and no correspondence will be entertained in this regard.
6. Applying form to the Trusts' Office does not guarantee a medical assistance from the Trust. The Trusts' decision to award medical assistance, or otherwise, will be informed to the applicant. No explanation whatsoever would be given if the application is rejected.
7. The Trust do not have any intermediaries / agents. Applicants are advised to beware of such individuals that claim to represent the Trusts and demand a share from the grant, if sanctioned. In case any such demands are made, applicants are requested to kindly bring the matter to the notice of the Chairman/Vice-Chairman of the Trust immediately.
8. Apart from the above instructions, it is hereby informed that the decision of the Trustees would be final and binding on all matters pertaining to the application.
9. Applicants can submit the medical application form through email only to *bhawanisevatrust@gmail.com.* The supporting documents, if any, asked by the Trust should be communicated to the applicant/patient and the same shall be submitted within 2 weeks from receiving the request for submission of the same (the Trusts may request for supporting documents through phone call / SMS / post/WhatsApp). If the requisite documents are not submitted within 2 weeks, the application will be closed and no further correspondence/communication on the matter shall be entertained.
10. Application forms with incomplete / manipulated / false information, with an intention to mislead the Trusts, shall be treated as void and **legal action will be taken** as deemed necessary.
11. Application form for a medical assistance is available on https://bhawanisevatrust.com
12. CHECK LIST attached.

Documents checklist (photocopies / scans- Through E-mail only):

MANDATORY DOCUMENTS:

1. Photo identity proof of applicant and patient (Anyone from the list below)
    a. Pan Card
    b. Aadhar Card

   c. Voter ID Card

2. Address Proof (Present or permanent address) (Any one from the list below)
   a. Ration Card
   b. Aadhar Card
   c. Voter ID Card
3. Latest Income Proof of all earning members
   a. If salaried - latest Income Tax Return / latest Salary Slip / Income Certificate from employer.
   b. If pensioner - Pension Passbook with last one year's entries
   c. If employed in an unorganized sector- Self declared income proof
4. Letter from the employer of all earning members of the family mentioning whether the patient is eligible for any kind of medical assistance. If not, then a letter from the employer to that effect mentioning the same.
5. Estimated cost of procedure at hospital duly certified by the Hospital administration on hospital's letter head to be send.

OTHE IMPORTANT POINTS:

1. **The trust considers those cases where the patient has been admitted or about to be admitted in the hospital for some critical health conditions which poses life threatening condition to the patient. Post hospitalization cases will not be considered by the Trust.**
2. Kidney Transplant cases, to submit an NOC letter from the Authorization Committee of the hospital.
3. If the treatment is ongoing or yet to commence, please attach a copy of the treating Doctor's certificate stating ailment, treatment advised and the break-up of the estimated cost of treatment.
4. If any payments are made by cheque and credit/debit card, kindly submit the copy of Bank Passbook/Statement showing the transaction to the hospital.
5. Attach list of individual donors & trusts applied, sanctioned and grants received.
6. Trusts may ask for additional documents at any point during the application processing.

NOTE: - Under no circumstances the payment shall be released directly to the patient/applicant. The amount of medical assistance given to the hospital shall be sole discretionary power of the trustee. The trust may consult the hospital administration before making any final decision on each application.