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| **Photo of Beneficiary**(Attested by Doctor) |

**Application form for Assam Arogya Nidhi**

1. Name of the Patient (in Block Letters)............................................................................................
2. Age ..............................................................................................
3. (A) Permanent address ..............................................................................................

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 (B) Address for correspondence ..............................................................................................

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1. Contact number ..............................................................................................
2. Father/Husband/Guardian’s name ..............................................................................................
3. Gender ..............................................................................................
4. Category (Gen/ST/SC/OBC) ..............................................................................................
5. Name of the applicant if not made

by the patient. ..............................................................................................

1. Applicant’s relationship to the

patient. ..............................................................................................

1. Disease for which treatment is

required .............................................................................................

1. Name of the Hospital where the

treatment is being received. ..............................................................................................

1. In case of private Hospital whether

the Hospital is registered Under

Clinical Establishment Act. 2010.

 If yes, the Registration No. .............................................................................................

1. Amount of financial assistant required ...........................................................................................

(Please submit the original bills/

 receipts in support)

1. Annual Income of patient ..............................................................................................

(Certificate from revenue circle

officer to be furnished)

1. Whether patient or guardian of

patient a Govt. servant/ govt. Pensioner .........................................................................................

(If yes, please give details)

1. Whether applicant has Atal Amrit Abhiyan

(AAA)Card and Prime Minister Jana

Arogya Yojana Card (PMJAY) AAA Card................... (Yes / No)

(Please tick mark ( ) whichever is PMJAY Cad................ (Yes / No)

appliable)

1. If applicant or guardian has above

mentioned card please mention the card No. AAA Card No. ....................................................... PMJAY Card No. ....................................................

1. (a) Whether any financial assistance

Under Assam Arogya Nidhi/AAAS or

any such scheme of Govt. of Assam

has been received earlier. ..............................................................................................

(b) If yes. Please furnish details ..............................................................................................

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 19. Details of the patient Bank Account Branch: ................................................................................. Account No. .........................................................................

 IFSC Code: ............................................................................

1. Other relevant information if any ..............................................................................................

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**DECLARATION**

I declare that the information given above is correct and complete in all respects and that I am in no position at all to arrange for/provide funds for the purpose stated above and hence this request for financial assistant.

Date: Signature of the applicant/patient

**Documents Required along with the application:**

* Photograph of the patient (Attested by Doctor)
* Income Certificate by Revenue Circle Officer(Attested)

original to be produced at the time of submission of Application Form

* Present Residential Certificate (Attested), if applicable.
* Bills /voucher/receipts (Original).
* Copy of the medical documents of treatment to be certified by treating Doctor/Hospital.
* Discharge Summary/Prescription (Attested)
* Photocopy of the fill page (1st page) Bank Passbook(Attested)
* Photocopy of PMJAY/AAA Card, if applicable.

NB: (A) No document submitted with application will be returned if the application is considered for financial assistance. So except for original bill/voucher/receipts, only attested copy of other documents to be furnished.

(B) The filled in application form is to be submitted, by hand or by post, to the office of the Mission Director, National Health Mission, Assam, Saikia Commercial Complex, Srinagar path, Christianbasti, G.S. Road, Guwahati-05.