

**Application for Financial Assistance under Umbrella Scheme Rashtriya Arogya Nidhi (RAN) and Health Minister's Discretionary Grant (HMDG)**

(Please tick mark (✓))

Rashtriya Arogya Nidhi		HEALTH MINISTER'S DISCRETIONARY GRANTS
Health Minister's Cancer Patient Fund		
Rare Diseases		

1	Name of the Patient (in Block Letters)	
2	Age	
3	(a) Permanent Address along with Pin Code	
	(b) Address for correspondence	
4	(a) Email Address (if available)	
	(b) Mobile No. (if available)	
5	(a) Father's /Mother's name	
	(b) Husband/wife's name	
6	Applicant's Relationship with the Patient	
7	Disease from which suffering (Name of the disease)	
8	Whether the applicant or the person on whom the patient is dependent, is an employee of Centre/State Government /Pensioner	
9	Monthly Income of the applicant and all family members from all sources issued by Tehsildar/BDO/SDO/SDM/DC. (Original Income Certificate should be attached. However, where online certificates are issued, self attested copy of income certificate may be enclosed)	
10	Amount of Financial Assistance required	
11	Whether financial assistance has been received from (a) any Ministry/Department other than Ministry of Health & Family Welfare such as Prime Minister National Relief Fund or CM Relief Fund for treatment of the same disease.  (b) Ministry of Health & Family Welfare earlier. If so, full details may be given.	
12	Attach self attested copy of the Ration Card	

13	Aadhar Card No., if any (Attach self attested copy)  I hereby share my Aadhaar Number issued by UIDAI & voluntarily give my consent to link my Aadhaar Number with my request for financial assistance under RAN/HMCPF/Rare Disease/HMDG Schemes. I also authorize Ministry of Health & Family Welfare to use my Aadhaar card details & identity information for authentication with UIDAI.	
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**DECLARATION**

1. I declare that the information given above is correct and complete in all respect.
2. I am not covered for benefits under Pradhan Mantri Jan Arogya Yojna (PMJAY).

**OR**

**(For rare diseases)**

Though I am covered under PMJAY, the amount of financial assistance required, indicated at Column 10 above, is only for packages not covered under PMJAY.

Date :

Signature of the Applicant/Patient

**TO BE FILLED BY THE M.O. INCHARGE OF THE CASE/HOSPITAL, ETC. WHERE THE PATIENT IS RECEIVING TREATMENT**

1. Name of the Patient & Hospital Registration No. \_\_\_\_\_

2. Gist of Reports of important Investigations done \_\_\_\_\_

3. Diagnosis-A short Note on the present clinical \_\_\_\_\_

conditions may be indicated \_\_\_\_\_

4. If the patient has been operated, please Indicate the date of operation \_\_\_\_\_

5.(a)The name of the Hospital where the patient is receiving treatment. \_\_\_\_\_

(b) Whether Hospital is Government or Private. \_\_\_\_\_

6. Amount recommended for treatment \_\_\_\_\_

7. Probable date of operation/intervention \_\_\_\_\_

8. Item wise break up of expenditure recommended in Column 6

Name of consumables/medicines required for operation/treatment	Cost (in Rupees)
1.	
2.	
3.	
4.	
5.	

9. Certified that the patient is not covered for benefits under PMJAY.

OR

(For rare diseases)

For patients covered under PMJAY, the amount recommended for treatment under Column 6 above, is only for packages not covered under PMJAY.

Signature of the HOD/MO-in-charge  
(Note below the level of Consultant/Assistant Professor with Official Seal)

1. Certified that the patient's particulars given above are true to the best of my knowledge and belief.
2. Details of Bank account (including IFSC Code) of the hospital to which funds are to be transferred (Bank details are to be provided in cases of hospitals, where revolving funds have not been set up).

Name of the Bank & Address	
Account No.	
IFSC code	
PAN/TIN/TAN	
Details of the account holder- name of hospital/institute	
Mobile Number	
E-mail id	

Signature of the Medical Superintendent of the  
Hospital/Medical Institution with Official Seal

Certificate to be furnished by the treating hospital regarding coverage of the beneficiary under AB-PMJAY

CERTIFICATE

1: Certified that \_\_\_\_\_ (Name of the patient) is not covered for benefits under Pradhan Mantri Jan Arogya Yojna (PMJAY) as per SECC data base.

OR

(For rare diseases)

2. Though \_\_\_\_\_ (Name of the patient) is covered under PMJAY as per SECC database, the amount of financial assistance required, as indicated at Column 10 of the Application form, is only for packages not covered under AB-PMJAY.

Signature of the HOD/MO-in-charge

(Note below the level of Consultant/Assistant Professor with Official Seal)