ANNEXURE-I

Application form
for Medical Aid under Dr. Ambedkar Medical Aid Scheme
(for SC and ST only)

Self Attested Photo of Patient -passport size.

1. Name of the Patient :.....

2. Name of Father/Mother/Husband/Guardian .....

3. Caste (the patient belongs to).....

4. Gender (Male /Female/Third gender).....Age.....

5. Residential Address of Patient with Pin Code .....

6. Phone Number/ Mobile Number and e-mail, if available.....

7. UIDAI No./ Aadhaar No. of beneficiary .....

8. Nature/Name of Disease .....

9. Date of Surgery/ Dialysis / Chemotherapy / Radiotherapy .....

10. Documents required for Kidney transplant i.e. Relationship with beneficiary (Form 14, format for the decision of the Authorization Committee Certificate) ....., Details of Donor of Kidney i.e. Name....., Age....., Blood Group....., UIDAI No. / Aadhaar No..... Address.....

11. Name of the Hospital from where treatment is sought and if the said hospital is covered under the Scheme (please mention the details (please see para-1 of the Scheme).....

12. Medical Aid required (Estimated Cost Certificate in Original issued by Medical Superintendent of the hospital to be attached).....

13. Annual Family Income from all sources.....

14. Whether the applicant has taken medical financial assistance or aid from any other sources, if so give details .....

15. **Documents Check**: Self attested certificates of following are attached:

(i)	Caste Certificate	: Yes /No
(ii)	Income Certificate	: Yes /No
(iii)	Ration Card/Aadhaar Card	: Yes /No
(iv)	Annexure-II & III duly filled/signed.	: Yes/No

16. It is certified that the information furnished above is true to the best of my knowledge and belief and nothing has been concealed.

I also undertake to ensure that (a) the Discharge Certificate and (b) Final Original Bills alongwith the (c) Utilization Certificate (UC) issued by the Hospital, shall be submitted to Dr. Ambedkar Foundation after my discharge from the hospital.

मनोज तिवारी / Manoj Tiwari
निदेशक / Director
डॉ. आंबेडकर प्रतिष्ठान / Dr. Ambedkar Foundation
सामाजिक न्याय एवं अधिकारिता मंत्रालय
M/o Social Justice & Empowerment
भारत सरकार, नई दिल्ली
Government of India, New Delhi

Signature of the Patient
(Either self /relative etc. or of Legal Guardian in case of Minor)

ANNEXURE-II

Estimate Certificate
(on hospital letter head)

for Medical Aid under Dr. Ambedkar Medical Aid Scheme
(for SCs and STs only)

Ref. No..... Date: .....

1. N.S. No. / Patient No. / Admission No. / C.R. No.....

2. Name of the Patient: .....

3. Name of Father/Mother/Husband/Guardian .....

4. Gender (Male /Female) .....Age.....

5. Nature of Disease .....

6. Date of Surgery/ Dialysis / Chemotherapy / Radiotherapy.....

7. Amount required for Surgery/ Dialysis / Chemotherapy / Radiotherapy .....

8. Whether the Hospital is a Central or State Govt. Hospital or recognized by either Central Govt. or State Govt. or is fully funded by either Central Govt. or State Govt. or is approved under CGHS Scheme of Central Govt. or fully funded under the list of hospitals indicated by name under the Dr. Ambedkar Medical Aid Scheme. (In support, a copy of the relevant order or notification may be enclosed) .....
.....

9. Whether the applicant has taken medical financial assistance or aid from any other sources, if so give details
.....

10. Mandate Form / Bank details of the Hospital (Annexure-III): .....

I undertake that the Hospital shall prepare (a) discharge certificate (b) final bills (c) Utilization certificate of medical aid granted by Dr. Ambedkar Foundation at the time of discharge of the patient from the Hospital and the same shall be immediately forwarded alongwith the Unutilized Aid if any, to Dr. Ambedkar Foundation.

Signature: -..... .....
(**Medical Superintendent of Hospital**)
Rubber Stamp bearing.....
Name & Designation.....

मनोज तिवारी / Manoj Tiwari
निदेशक / Director
डॉ. अम्बेडकर प्रतिष्ठान / Dr. Ambedkar Foundation
सामाजिक न्याय एवं अधिकारिता मंत्रालय
M/o Social Justice & Empowerment
भारत सरकार, नई दिल्ली
Government of India, New Delhi

ANNEXURE-III

MANDATE FORM

To

The Director,
Dr. Ambedkar Foundation,
15, Janpath, New Delhi-110001

SUBJECT: ELECTRONIC CLEARING SERVICE (CREDIT CLEARING)/REAL TIME GROSS SETTLEMENT (RTGS) FACILITY FOR RECEIVING PAYMENTS FOR "DR. AMBEDKAR MEDICAL AID SCHEME".

DETAILS OF HOSPITAL BANK ACCOUNT: -

NAME OF THE PATIENT	
NAME AND COMPLETE CONTACT ADDRESS OF HOSPITAL	
(i) TELEPHONE NO.: (ii) FAX NO : (iii) E-MAIL ID OF HOSPITAL (iv) Tel. No. of the contact person for clarification.	
NAME OF ACCOUNT HOLDER	
HOSPITAL ACCOUNT NUMBER	
NAME OF THE BANK WITH (i) COMPLETE ADDRESS / (ii) TELEPHONE NUMBER AND (iii) E-MAIL ID for clarification if needed.	
IFSC CODE OF BANK	
MICR CODE OF BANK	
BANK BRANCH CODE NO.	

DATE OF EFFECT: -

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all for reasons of incomplete or incorrect information, I would not hold the user institution responsible. I have read the option invitation letter and agree to discharge responsibility expected of me as a participant under the Scheme.

(.....)
Authorized Signature of the Hospital
with Stamp
bearing Name and Designation

Date:

Certified that the particulars furnished above are correct as per our records.

(Authorized Signature of the Bank
with Bank's Stamp) with Name & Designation

Date:

1. Please attach a photocopy of cheque alongwith the verification obtained from the Bank.
2. In case your Bank Branch is presently not "RTGS enabled", then upon its up gradation to "RTGS Enabled" branch, please submit the information again in the above proforma to the Department at earliest.

मनोज तिवारी / Manoj Tiwari
निदेशक / Director
डॉ. अम्बेडकर प्रतिष्ठान / Dr. Ambedkar Foundation
सामाजिक न्याय एवं अधिकारिता मंत्रालय

ANNEXURE-IV

Ref. No. ..... Date: .....

Utilization Certificate

(on hospital letter head)

Dr. Ambedkar Medical Aid Scheme of
Dr. Ambedkar Foundation (DAF)

(after surgery duly filled and submitted by Hospital to DAF)

1. DAF's Sanction order No. and date :
2. Name of Patient :
3. Gender :
4. Hospital Patient No. / CR No. / N.S. No. / Admission No. :
5. Medical Aid received from DAF / Cheque No., Date & Amount (Rs.), if so. :
6. Medical Aid received from any other sources, if any / details i.e. Cheque No., Date & Amount (Rs.) :
7. Date of Surgery/Chemotherapy/Dialysis :
8. Date of Discharge :
9. Total Expenditure (in Rs.) incurred on surgery/ Dialysis /Chemotherapy / Radiotherapy :
   - (i) Bill No. & Date :
   - (ii) Bill Amount (Rs.) :
10. Unutilized Amount (Rs.) and details of Refund to DAF i.e. date, mode etc. :
11. Remarks :

(Note :- Please attach all respected bills with the utilization Certificate)

Medical Superintendent /
Competent Authority of the Hospital
Rubber Stamp .....

मनोज तिवारी / Manoj Tiwari
निदेशक / Director
डॉ. अम्बेडकर प्रतिष्ठान / Dr. Ambedkar Foundation
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