Financial Assistance Application Form

Please provide all details in legible handwriting or in print
Attach certificates where ever necessary

Section I: Patient Information

First Name: Middle Name: Last Name:

Address:

Phone No. : Home Mobile:

Date of Birth:

Marital Status:

Hospital where treatment is being given:

Docket/File No.:

Consulting Doctor:

Are you covered by: Health Insurance: ESI:

If yes, provide details and a copy of the insurance cover:

Policy No. :

Name of Insurance Provider:

Are you covered under the medical reimbursement scheme of your employer: Yes
No

Are you receiving aid under the Chief Minister Cancer Relief Fund: Yes No

Do you have any family member working as a Central or State Government employee: Yes
No

Section II: Family Income

Provide income for yourself, your spouse and other earning family members (if applicable)

Sr. No.	Name	Relation with Patient	Annual Income (Rs.)

Section III: Family Information

Provide information about your family members (The term family includes the patient, the patient's spouse, and all of the patient's children under 18 years (natural or adoptive) living with the patient. In case of patients under the age of 18 years, the term family shall include the patient, the patient's natural or adoptive parent(s), and the parent(s) children under 18 (natural or adoptive) who live in the patient's home.

Sr. No.	Name	Relation with Patient	Date of Birth

By signing below, I certify that everything stated in the application and the attachments is true.

Patient/ Guardian's Signature

Name:

Date:

<u>Documents to be attached along with the application form</u>

1. ID proof (with address):
2. Biopsy/FNAC report:
3. Form16 or pay slip or bank statement:

Section IV: Medical Information (To be provided by treating doctor)

Type of Cancer: ☐

Stage: ☐

Intent of treatment: Curative Palliative

Duration of Treatment: ☐ years ☐ months

Course of treatment: Please provide all details of past and planned treatment

Is the patient likely to complete planned treatment?

Will the patient get any concession from the hospital during the treatment (e.g investigations, admission, consultation, medicines etc)?

If you answered yes to the above question, please give details:

Please provide total cost of treatment (with detailed break-up)

- Investigations
- Chemotherapy
- Surgery
- Radiotherapy
- Supportive care
- Others (specify)

Total

Would the patient require rehabilitation after completion of treatment?

Yes: ☐ No: ☐

If yes, please provide details of nature of help that would be required:

Comments: Please provide relevant information

What is the amount expected from Can Fight Cancer Society? _____

Does the hospital agree to give a copy of the bills to Can Fight Cancer Society after approval of grant?

The amount, if approved, can be deposited in the form of a cheque to the institution into the patients account. Please provide details i.e cheque to be drawn in favor of _____

By my signing below, I certify that everything I have stated in Section IV is true.

Signature

Full Name:

Stamp: **Date:**

Section V: For Office Use Only

Application No: _____

Form submitted on: _____

Form received by: _____

Case discussed on: _____

Members present: _____

_____

Comments:

Amount Approved: _____

Signatures of at least three Core Members

Signature 1 **Signature 2** **Signature 3**