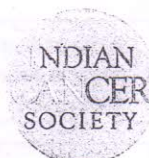


INDIAN CANCER SOCIETY

74, Jerbai Wadia Road, Parel, Mumbai - 400012. Tel. No: 022 - 24125238/24161875/24139445

Website: www.indiancancersociety.org

Email: info@indiancancersociety.org



Fighting Cancer Since 1951

Application Form for Financial Grant Under Cancer Cure Fund Project

Form No **002846**

Guidelines

- This application form is FREE and no payment whatsoever should be made for procuring it.
- Please ensure that all the requested documents are enclosed with this form. INCOMPLETE application forms will be REJECTED. A NEW FORM WILL NOT BE GIVEN IN CASE OF ANY ERROR IN FILLING UP THIS FORM.
- Contact person has to be the patient's immediate family member (father / mother / husband / wife / son / daughter / brother / sister) OR self, above 18 years only. The contact person should be available for all queries.
- Applicants are hereby informed that a very serious view would be taken if any information given / submitted is found to be false or manipulated with an intention to mislead Indian Cancer Society (ICS).
- Submitting a completed application form to the ICS office does not guarantee financial assistance.
- The decision of ICS will be final and you will be informed accordingly by the hospital.
- Please DO NOT enclose original documents with this application form.
- This application form has to be submitted in original only.
- ICS encourages all patients to apply for all Govt. grants like Prime Minister's National Relief Fund, Chief Minister's Fund etc.

PLEASE USE BLOCK LETTERS FOR FILLING THE APPLICATION FORM		
Name of the Patient: Mr. / Mrs. / Miss / Mast.		Photo
Hospital - Case No / Medical Registration No.		
Date of Birth:	DD / MM / YYYY	
Gender:	Male <input type="checkbox"/> / Female <input type="checkbox"/> (Tick the appropriate Box)	
Permanent Address:		
	City:	State:
	Pin-code:	
Address and telephone number for correspondence in city of treatment		
	City:	State:
	Pin-code:	
Name of Contact Person :		Relationship to the Patient:
Tel No :		Mobile:
Tel No: (at least one land line number is mandatory)	Mobile no. of the Patient : The mobile no. must remain in use throughout the treatment period	Landline with Std-code:
Occupation of Patient (Tick one):	Govt. / Pvt. / Farmer / Labourer / Self Employed / Professional / Student / Un-employed / Housewife / Child	
If student:	Name of Institution:	
	City:	State:
	Currently studying in Std. / Year	
If Working/ Business	Name of Organization:	
	City :-	State :-
	Designation:	
	Employed since :-	

Is the patient covered under medical insurance scheme like Medclaim?	Yes / No
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Hospital Details	
Type of Cancer:	
Name of the Hospital and City :	
Date of Registration at the Hospital	
Category of the Patient (As per Hospital Classification)	
Estimated treatment expenses (As per Cost Certificate) :	Rs.
Has the patient incurred expenses towards this treatment?	Yes / No
If Yes, Amount incurred Rs. _____ (Patient should submit copies of bills / cash memos)	How was it incurred ?
Family's contribution towards future treatment expenses:	
Amount in Patient's Hospital account on date of application :- Rs.	

Family Details						
Sr.	Name of Patient & Immediate Family Members	Relationship to the patient	Age	Occupation	Monthly Income (Rs.)	Income Certificate enclosed Yes/No
Total family income (annual) : Rs.						

Please Give Details Regarding Financial Assistance Sought From Other Trusts / Organizations:			
Sr.	Name of Trust / Organization	Applied on	Amt Sanctioned or to be considered / OR refunded, Pending any other

TO BE FILLED IN BY TREATING DOCTOR

1	Name of the Patient:	Mr./Mrs./Miss/Mast					
2	Diagnosis :						
3	ICD Code :						
4	Treatment Protocol :						
5	Risk Category :	Standard Risk / Intermediate Risk / High Risk / Good Risk / Low Risk (Tick one)					
6	Intent of treatment :	Curative / Palliative (Tick one)					
7	Expected 5 Yrs. Survival Rate % :						
8	Estimated Duration of treatment:						
9	Estimated treatment expenses: (Please indicate total cost)	Rs.					
10	Time line for treatment expenses :	0-3 months	4-6 months	7-9 months	10-12 months	> 12 months	Total (Rs.)
11	Compliance & Regularity of Patient :	Regular / Irregular (Tick one)					

Break up Expenses

Chemotherapy : (Rs.)	
Surgery : (Rs.)	
Radiotherapy : (Rs.)	
Prosthesis : (Rs.)	
Supportive Care : (Rs.)	
Bone Marrow Transplant : (Rs.)	
Any other : (Rs.)	

N. B. Kindly ensure that the Total of Break up Expenses equals the Estimated treatment expenses as stated above

DOCTOR'S NOTE

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DOCTOR'S DETAILS

Name of Doctor:		
Contact nos.	Landline:	Mobile:
Email Address:		
Registration No. of the Doctor:		
Name of Hospital:		Stamp:
Signature:		

PATIENTS'S / GUARDIAN'S CONSENT FORM

I am applying for financial aid for treatment of cancer for myself / my child from Indian Cancer Society.
I DECLARE THAT THE PARTICULARS AND INFORMATION CONTAINED IN THIS APPLICATION ARE COMPLETE AND CORRECT.
I AM ALSO AWARE THAT SERIOUS ACTION WOULD BE TAKEN IF ANY OF THE ABOVE PARTICULARS OR INFORMATION IS FOUND TO BE FALSE OR MANIPULATED.

I have no objection to the usage of my / my child's image, name and other details on the website of ICS and in your brochure, pamphlets, advertisement of any kind, publication or any other form of media.

Yours faithfully,

(Signature of Patient/Guardian ONLY in case the applicant is a minor)

(Full Name of Patient)

(Full Name of Contact Person)

(In case of thumb impression, please get it attested by an authorized person-Right thumb for women and left thumb for men)

COMMENTS BY MEDICAL SOCIAL WORKER

(Signature/Full name of Medical Social Worker)

Date:

Place:

Stamp of Hospital

LIST OF ENCLOSURES

1. Hospital Registration Page

2. Ration Card OR BPL card OR original affidavit.

3. Cost Certificate with complete break up on Hospital letter-head.

4. Income Certificate OR Salary slip/Employer's salary certificate (for each earning member of the family).

5. Any Other

COMMENTS BY DUE DILIGENCE TEAM OF INDIAN CANCER SOCIETY (FOR USE BY ICS ONLY)

Date:

Signature

ADDITIONAL COMMENTS BY GOVERNING ADVISORY COUNCIL (FOR USE BY ICS ONLY)

Date:

Signature

(DDT member attending the GAC meeting)

અન્ય કોઈપણ રીતે સંપૂર્ણ માફી ન હોય અને જે દર્દીના કુટુંબની વાર્ષિક આવક રૂ. ૧,૦૦,૦૦૦/- (રૂ. એક લાખ) સુધીની હોય તેવા દર્દીઓને નિદાન થયા બાદ મટી શકે તેવા કેન્સરમાં ઈન્ડિયન કેન્સર સોસાયટી તરફથી આર્થિક સહાય અપાવનાર છે. આ માટે આવા દર્દીઓએ કેસમાં તેમની સારવાર કરતા યુનીટના વડા પાસે કેસમાં ભલામણ લખાવી રૂમ નં. ૧૫ જામાં મળવું.

- આવકના પુરાવા માટે નોકરી કરતાં હોય તેઓએ પગારની સ્લીપ તથા કુલ જે આવક હોય તે અંગેનું એફીડેવીટ રજૂ કરવાનું રહેશે.
- ઘંઘો કરતા હોય કે મજૂરી કરતા હોય તેઓએ મામલતદાર/ ટી.ડી.ઓ.
 - (૧) કલેક્ટર ઓફિસમાંથી આવકનો દાખલો
 - (૨) રહેઠાણના પુરાવા માટે
 - (૩) રેશનકાર્ડ, ઈલેક્શન કાર્ડ, યુનીક આઈ.ડી. (આધાર)ના પુરાવા રજૂ કરવાના રહેશે.
 - (૪) ફોટોગ્રાફ-૨
 - (૫) એફીડેવીટ

-
- આ સ્કીમ હેઠળ દર્દીને લેવામાં આવે તો તેઓએ ડોક્ટરની ટીમ જ્યારે બોલાવે ત્યારે આવવાનું રહેશે.
 - આવા દર્દીઓએ ફાઈલની એક ઝેરોક્ષ તેઓ પાસે રાખવાની રહેશે. અસલ ફાઈલ હોસ્પિટલમાં જમા ન કરાવનારને આ સ્કીમનો લાભ બંધ કરવામાં આવશે.
 - આ સ્કીમ હેઠળના દર્દીએ બાંહેધરી આપવાની રહેશે કે તેઓ શરૂથી અંત સુધી અત્રેની હોસ્પિટલમાં ડોક્ટરની સલાહ પ્રમાણે જ સારવાર લેશે.

(15) 205

Indian Non Judicial Stamp Of Rs.20/-

Affidavit

I _____ Self / H/o / W/o / S/o / D/o /
F/o _____ Aged about _____ Years,
Occupation _____ do hereby solemnly affirm and declare as follows :-

1. That I / We are residing at _____
_____ since _____ Years.
2. That I am Citizen of India
3. That my family Income is Rs. _____ (Rs. _____)
4. That I am / My Wife / Husband / Father / Son / Daughter is suffering from Cancer disease and having to get fund for treatment at M. P. Shah Cancer Hospital, Ahmedabad from Indian Cancer Society as I / We can not affordable for such treatment I / we need to do this affidavit

That all the statements made above are true to the best of my knowledge and belief.

Signature of deponent.

Identified by me

Advocate