

Date of Application _____



FINANCIAL AID APPLICATION FORM

(To be submitted by Hospital Authorities)

A) PERSONAL DETAILS

Name of the Patient: Mr/Mrs/Ms _____
First Name Middle Name Surname

Age: _____ years _____ months **Gender:** Male / Female / Other

Aadhar Card No. _____ **PAN No.** _____

Name of the Applicant: Mr/Mrs/Ms _____
(Must be Self / Family Member) First Name Middle Name Surname

Patient's relationship to the Applicant: _____

Mobile No. _____ **Alternate No.** _____ **Email** _____

Address of Family: _____

Family details:

| Sr. No. | Name of Family Members | Relationship to Patient | Age | Occupation | Monthly Income (Rs.) |
|---------|------------------------|-------------------------|-----|------------|----------------------|
| | | | | | |
| | | | | | |
| | | | | | |

*If above space is insufficient, please add the details in an additional sheet

B) TRANSPLANT DETAILS

Organ Transplant Type: Live Donor / Cadaver donor

If Live donor, details of Donor:

Name _____ Age _____ Relation with Patient _____

Name of Hospital: _____ **City:** _____

Case Summary: _____

Recommending Doctor: _____ **Date of Transplant:** _____

C) FUNDS

Total cost of Transplant (including patient/donor and hospital stay): Rs. _____ lakhs

Family/Personal Contribution: _____ **Funds received from Relatives/Friends:** _____

Mediclaime received / eligible from insurance company or Employer _____

| Sr. No. | Source | Name of Trust / Organisation | Applied on (Date) | Amount sanctioned / considered |
|---------|------------------------------|------------------------------|-------------------|--------------------------------|
| 1. | Crowdfunding | | | |
| 2. | Government Funding | | | |
| 3. | NGOs/Trusts/Grants/Charities | | | |
| 4. | Private Individuals | | | |
| 5. | Others | | | |

Documents Required: Aadhar Card, PAN Card, Latest Income Proof, Latest Bank Statement, Passport sized photos x 2, Hospital's Estimate Letter, NOC letter from the Authorization Committee approving the transplant

I, (Applicant Name) _____, hereby declare that the above facts stated / mentioned, and particulars given by me are true and correct.

Signature of Applicant

Signature of Hospital Authority & Seal
 Name: _____
 Designation: _____

INSTRUCTIONS

1. Applications for the grant should be submitted by the Hospital's authorities or Transplant Coordinator.
2. Applicant must be self or patient's immediate family member (*Parent/son/daughter/spouse/sibling*).
3. Applicant must be above 18 years of age.
4. Applications received after the patient is discharged from the hospital will not be accepted.
5. Application must be made atleast 15 days prior to transplant date.
6. Incomplete forms will not be accepted.
7. Original Bills / receipts from hospital should be submitted upon request. Duplicate bills / receipts / certificates will not be accepted.
8. Final decision on the applications (based on eligibility criteria), will depend on the discretion of the internal committee set up for this purpose.
9. The Foundation's decision to award financial aid or otherwise, will be informed to the Hospital and Applicant. No explanation whatsoever would be given if the application is rejected.
10. Hospitals to email the application form, duly filled, along with the supporting documents, at anudaan@mohanfoundation.org. **PLEASE NOTE: one complete set of originals must be couriered to our office at 284 F, B-Block, Sushant Lok Phase-1, Landmark: Behind Vipul Square/Convergys Building, Gurgaon – 122002, Ph: 0124 – 4115211 (9am to 5pm), without which the application will not be processed.**
11. The Foundation may ask for additional documents at any point of time while processing the application.
12. The Foundation will transfer the payment directly to the Hospital's account.
13. This application is available [here](#)