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 102844

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 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 US	E BLOCK LETTERS FO	or filling the	APPLICATION	NFORM
Name of the Patient: Mr. / Mrs. / Miss / Mast.				E MATE PURENT TO THE EXTREME
Hospital - Case No / Medical Registration No.				Photo
Date of Birth:	DD / MM / YYYY			Piloto
Gender:	Male / Female	(Tick the appropriate	Box)	min medial to angul
Permanent Address:		Distance of the control of the contr		asimutti.
remanent Address.	City:	State:		Pin-code:
Address and telephone number for correspondence in city of treatment	City:	State:		Pin-code:
Name of Contact Donor	City:	State:		
Name of Contact Person :	to the second se		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 u	se throughout the treatm	Landline with Std-co ent period	ode:
Occupation of Patient (Tick one):	Govt. / Pvt. / Farmer / Labour Child	er / Self Employed / Pr	rofessional / Student /	Un-employed / Housewife /
If student:	Name of Institution: City:	Market Co.	State:	of Familia gentle
	Currently studying in Std. / Ye	ar		*
If Working/	Name of Organization: City:-		State :-	
Business	Designation: Employed since :-			

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Ho	spital Details						
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	e of Registration at the pital		# proceed at			komen copy kna	
	egory of the Patient (As per pital Classification)	llw \n					A SESSE POR MARKETER SESSE SES
	mated treatment expenses per Cost Certificate) :	Rs.	y notice against yes."	read to	i Marana santa sa manana manana	ning, yegy garri ha maani heelgan or m	mount ement on the block of
	the patient incurred expenses ards this treatment?	Yes	/ No	per of per	denga bannat nedasi ggu sir	es ad the sity box to	om ed disk sol fornatideal sett during en form met er ordat
	es, Amount incurred Rs ient should submit copies of bills	/ cash	memos)	er ki	How was it	incurred ?	u Cestas Le agrino de Su
Fan	nily's contribution towards future	treatm	ent expenses:				towed said be one
Am	ount in Patient's Hospital accou	nt on da	te of application :-	Rs.			Character and Jane
Fai	nily Details			- 10			
r.	Name of Patient & Immediate I Members	Family	Relationship to the patient	Age	Occupation	Monthly Income (Rs.)	Income Certificate enclose Yes/No

Sr.	Name of Patient & Immediate Family Members	Relationship to the patient	Age	Occupation	Monthly Income (Rs.)	Income Certificate enclosed Yes/No
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		not having	U Committee
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T	o be filled in by treatin	G DOCTOR					
1	Name of the Patient:	Mr./Mrs./Miss	/Mast		intOvil)	i I knie	1/1/11/19
2	Diagnosis :	LOSE MUNICIPALIO MICHIERA MICHIA	collection Lichen	a V Programed me		and the second second	of grantings
3	ICD Code :	O HARRYTHAN	Section for the	MARINE DE	autor comb.	CHOMIST TURY OF	ANY CALLS VI
4	Treatment Protocol :						
5	Risk Category :	Standard Risk /	Standard Risk / Intermediate Risk / High Risk / Good Risk / Low Risk (Tick one)				
6	Intent of treatment :	Curative / Palli	Curative / Palliative (Tick one)				
7	Expected 5 Yrs. Survival Rate %:						
8	Estimated Duration of treatment:	Section of Francisco and Section and Section of Francisco Section of Proceedings of Section 1					
9	Estimated treatment expenses: (Please indicate total cost)	Rs.		Spring Best on a	a di	Service description	SLA.
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 Patien	t: Regular/	' Irregular (Tick o	ne)			*
200990	eak up Expenses						
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Sup	portive Care : (Rs.)	An artist in the	altitude and	*	4		
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Any	other : (Rs.)	Talka k Tala				P. Marine	e que esta y su
N. E	3. Kindly ensure that the Total of Bre	eak up Expenses	equals the Estim	ated treatment	expenses as stated	d above	2
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DO	OCTOR'S DETAILS						
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Cor	ntact nos.	Landline:	100		Mobile	:	The second second
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ICS Cancer Cure Fund Page - 3

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 CONTAIN	FD IN THIS APPLICATION ARE COMPLETE AND CORRECT.
I AM ALSO AWARE THAT SERIOUS ACTION WOULD BE TAKEN IF A	NY OF THE ABOVE PARTICULARS OR INFORMATION IS FOUND TO BE
FALSE OR MANIPULATED.	
	to the standard of ICC and in your brookurs namphlats
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 med	ia. (Section costs) total forbad?
Yours faithfully,	
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(Signature of Patient/Guardian ONLY in case the applicant is a minor)	
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(Full Name of Patient)	(Full Name of Contact Person)
(In case of thumb impression, please get it attested by an authorized personal content of the co	on-kight thumb for women and left thumb for meny
COMMENTS BY MEDICAL SOCIAL WORKER	
	and the state of t
	SED YOU'L DESIGNATION OF THE PARTY OF THE PA
(Signature/Full name of Medical Social Worker)	
(Signature/Full hame of Medical Social Worker)	
Date: Place:	Stamp of Hospital
Dutch	
LIST OF ENCLOSURES	
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 Am Other	Test to the second state of the second state o
5. Any Other	1 MC storing and more life and life
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Date:	Signature
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અન્ય કોઈપણ રીતે સંપૂર્ણ માફ્રી ન હોય અને જે દર્દીના કુટુંબની વાર્ષિક આવક રૂાં. ૧,૦૦,૦૦૦/– (રૂા. 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 ઉત્તે કોં

- આવકના પુરાવા માટે નોકરી કરતાં હોય તેઓએ પગારની સ્લીપ તથા કુલ જે આવક હોય તે અંગેનું એફીડેવીટ રજૂ કરવાનું રહેશે.
- ▶ ધંધો કરતા હોય કે મજુરી કરતા હોય તેઓએ મામલતદાર/ ટી.ડી.ઓ.
 - (૧) કલેકટર ઓફિસમાંથી આવકનો દાખલો
 - (૨) રહેઠાણના પુરાવા માટે
 - (૩) રેશનકાર્ડ, <u>ઈલેક્શન કાર્ડ</u>, યુનીક આઈ.ડી.(આધાર)ના પુરાવા રજુ કરવાના રહેશે.
 - (૪) ફોટોગ્રાફ-૨
 - (૫) એફિડેવીટ
- ➢ આ સ્કીમ હેઠળ દર્દીને લેવામાં આવે તો તેઓએ ડોકટરની ટીમ જયારે બોલાવે ત્યારે આવવાનું રહેશે.
- ➢ આવા દર્દીઓએ ફાઈલની એક ઝેરોક્ષ તેઓ પાસે રાખવાની રહેશે. અસલ ફાઈલ હોસ્પિટલમાં જમા ન કરાવનારને આ સ્ક્રીમનો લાભ બંધ કરવામાં આવશે.
- ➢ આ સ્કીમ હેઠળના દર્દીએ બાંહેઘરી આપવાની રહેશે કે તેઓ શરૂથી અંત સુધી અત્રેની હોસ્પિટલમાં ડોક્ટરની સલાહ પ્રમાણે જ સારવાર લેશે.

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Indian Non Judicial Stamp Of Rs.20/-

Affidavit

Ι	Self / H/o / W/o / S/o	/ D/o /
F/o	Aged about Yea	ars,
Occupation do hereby sole	emnly affirm and declare as follows	:-
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 treatr	nent at M. P. Shah Cancer Hospital,	Ahmedaba
from Indian Cancer Society as I /We car	not affordable for such treatment	I / we need
to do this affidavit		
That all the statements made abo	ve are true to the best of my knowle	dge and
belief.		
	Signature of deponent.	
	Identified by me	
	Advocate	