APPLICATION FORM FOR
"A.P.CHIEF MINISTER's RELIEF FUND"

Latest Photo

To
The Hon'ble Chief Minister,
Govt. of Andhra Pradesh,
A.P.Secretariat, Velagapudi,
Amaravathi.

(Fields must be filled in Block Letters only)

(i) (A) Name of the Patient :
(B) Aadhar Card Number of the Patient :
(C) Ration Card Number :
(D) Bank Account Number :
(E) Bank IFSC Code :
(F) Bank Name and Address :
(ii) Voter Id Number Mobile Number :
(iii) Son/Daughter/Wife of :
(iv) Date of Birth and Age of the Patient :
(v) (A) Address for Correspondence:-
(vi) Door Number :
Street :
Village Mandal :
District :
Name of the Assembly Constituency :

1 – A If the Application is not made by the patient: (Please fill the below information also)

a) If the Patient belongs to Child :- YES/ NO (***Please tick appropriate***)
b) Is the Patient alive :- YES/ NO (***Please tick appropriate***)
c) Name of the Applicant
d) Relationship to the patient
e) Applicant Aadhar Card
f) Bank Account Number
g) Bank IFSC Code
h) Bank Name and Address

Purpose for seeking:- **(i) Medical Relief / (ii) Letter of Credit / Treatment Details (if Medical Relief only)**

If Financial Assistance: Medical Relief / Letter of Credit

Disease Description:

Hospital Name
Address of the Hospital

(Hospital Ph.No, eMail Address, Web address)

Name of the Treated Doctor :

Date of Admission into Hospital	**(dd/mon/yyyy)**	**Date of Discharge from Hospital**	**(dd/mon/yyyy)**
Date of Surgery	**(dd/mon/yyyy)**	**In Patient Number**	

(iii) **Details of Expenditure towards Medical:-**

a) Amount spent to the Hospital towards surgery / treatment :

b) Amount spent for Diagnosis and Ambulance Charges :

c) Amount Spent for Medicines :

d) Any Others :

e) Any other Discounts (-) :

f) Total Amount spent by the Applicant (i+ii+iii+iv-v) :

(iv) Amount Requested :- Rs :

(v) Any Other Information:- :

(vi) Recommended By:-

a) Name :
b) Designation :
c) Constitution No :
d) Any Other Details :

PHYSICIAN'S REPORT

TO BE FILLED BY THE TREATING PHYSICIAN OF THE CASE/HOSPITAL ETC. WHERE THE PATIENT IS RECEIVING / HAS RECEIVED THE TREATMENT.

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1. Patient's Name :
2. Name of the Hospital :
3. Hospital Registration Number & Date of Validation :
4. IP Number of the Patient, A short note on the present clinical condition of the patient :
5. Important investigation done :
6. Diagnosis :
7. Details of treatment :

   Indicate date & other details :

   a. Medicine Management, ICU :
   b. Surgery :
   c. Chemotherapy :
   d. Hemodialysis :
   e. Others :
8. Amount of expenditure :

   a) Cost of important investigations. :
   b) Cost of surgery :
   c) Cost of medicines, etc. :
   d) Hospital Charges :
   e) **Total** :

Recommended By

Signature
Treating Doctor with Official Seal along with Registration No issued by the Medical Council of India

Approved By
Signature of the Medical Superintendent In charge of the Hospital with Official Seal.

To
The CMRF Division, Andhra Pradesh.

N:B:- The application should be submitted during the treatment or maximum within one month from the date of discharge from the hospital

DECLARATION

I Mr./Mrs_________________________________son/daughter /wife of Mr./Mrs.____________aged .... years hereby declare that the information given above is correct and complete in all aspects. I also declare that neither me nor my family dependents are employees of the Central / State Government and further no other assistance from either from State nor Central Government Schemes and Insurance Claims. In case if any identified subsequently that, any fraudulent or misleading information has been furnished by me, I shall be liable for legal action as deemed.

Signature of the Applicant / Signature of the Patient

****** Application made within 100 days from the date of discharge from the Hospital**

Check List:- Following Documents are mandatory to apply Chief Minister Relief Fund.

a. Copy of Aadhar Card,
b. Copy of Ration Card or Income Certificate from Meeseva,
c. Copy of Bank Pass Book,
d. Copy of Bank Barcode,
e. Copy of Voter ID,
f. Physician's Report

For LOC :

1) Essentality Certificate,
2) Emergency Certificate,
3) Report for evidence,
4) Declaration from the Hospital that the treatment should be done through Letter of Creidt.

For Medical Relief : -

1) Original Discharge Summary
2) Original IP Final Bill
3) All Payment receipts to Hospital in Original
4) Consolidated list of all bills enclosed.

నియోజకవర్గ ధృవీకరణ

(CONSTITUENCY DECLARATION)

గౌరవనీయులైన ఆంధ్ర ప్రదేశ్ ముఖ్యమంత్రి వర్యులు
శ్రీ నారా చంద్ర బాబు నాయుడు గారికి,

విషయము: ------------- జిల్లా, ---------------- నియోజక వర్గం, ముఖ్యమంత్రి సహాయనిధి నుండి ఆర్థిక సహాయము కొరకు విన్నపము.

ఆర్యా!

అర్జీదారుని పేరు :

చిరునామా :

ఫోన్ నెం :

ఆదార్ కార్డు నెం :

వైద్యం కోసం ఖర్చు చేసిన మొత్తం: రూ||----------------

లెటర్ అఫ్ క్రెడిట్ కొరకు : అవును ☐

వైద్యం కోసం అంచనా మొత్తం:

(ఒరిజినల్ కాపీ జతపరచవలెను)

పైన కనబరిచిన అర్జీదారుడు నా నియోజక వర్గంలో నివాసం ఉంటున్నాడు అని ధృవీకరణ చేయడమైనది.

తేది:

భవదీయ

( )

నియోజకవర్గం:

సంఖ్య:

స్టాంప్: (తప్పనిసరిగా వేయవలెను)