NEUROLOGY FOUNDATION

Charitable Trust

Registration No. E-17626 (Mum)

Correspondence Address: 403, Marathon Icon, 4th floor, Opposite Peninsula Corporate Park, Lower Parel (W), Mumbai: 400013, India.

Phone: 022-66106249 / 9167622905 Email: info@neurologyfoundation.in

SAHAY / UPCHAR PROJECT

Name of Patient: Gender:

Age: Occupation:

Home/Native Address: Mobile Number:

Landline: E-mail Address:

Work Address: Work Number:

Total Number of Family Members:

Total Monthly Household Income:

Name of other Trusts/Agencies applied to & amount received:

Details of all previous aid from Neurology Foundation:

Signature of Patient/ Guardian:

Date: Place:

TO BE FILLED BY TREATING DOCTOR

☐ Hospitalised Patient ☐ Outpatient ☐ Medication / Assistive Aid

Diagnosis:

Treatment/Medication/Assistive Aid required:

Total Estimate of Treatment/Medication/Assistive Aid: Rs.

Cheques will be issued in the name of organisation/institution/chemist/hospital
Individual patient account will not accepted

CERTIFIED BY TREATING DOCTOR:

Name:

Hospital:

Hospital Address:

Tel No:

Signature:

Date: Place:

TO BE FILLED IN BY NEUROLOGY FOUNDATION CHARITABLE TRUST ONLY:

Date of Receipt of Application:

Document enclosed as per checklist: YES / NO

Amount expected:

Amount sanctioned

Payment details:

Is Claim valid:

Checked by:

APPROVED BY TRUSTEES:

Name: Signature:

Name: Signature:

REMARKS:

To Date:
The Trustees,
Neurology Foundation Charitable Trust,
Room No.131, Medical Research Centre
Bombay Hospital, New Marine Lines,
Mumbai 400020

Dear Sir / Madame,

I,
am presently residing at

I earn approximately Rs. per month and the total monthly income of my entire family is Rs. .

I/one of my family member Mr/ Ms / Master
is suffering from
And requires necessary suitable medical treatment/ assistive aid/ medication. As I/ my family am/are not financially capable to meet the expenses for my/his/her treatment, I appeal to you to donate the cost of the medical treatment/ assistive aid/ medication required.

I have completed and signed the medical aid application form given to me by Dr. and am submitting the same herewith with all the required documents.

Kindly do the needful.

Thanking you.

Yours sincerely,

Signature

DOCUMENT CHECKLIST

1. Identity proof of patient and/or applicant
   (Passport/Pan Card/Drivers License/Ration Card/ School identity card/ Recent Bank Statement/Passbook Others)

2. Proof of employment (Of patient and/or applicant)

3. Proof of Salary (Of patient and/or applicant)

4. Letter/Statement of referring doctor

5. Supporting medical documents of illness
   (Please attach self attested copies ONLY)

GUIDELINES

1. The aid will be restricted to patients with neurological disorders.

2. The aid will be restricted to the patients who are not financially capable of meeting the treatment costs and/or who cannot get adequate/ sufficient government sponsored treatment and/ or other free/private treatment.

3. The concerned doctor is required to submit a statement outlining the treatment details and the patient's condition.

4. Payment shall be made by us to the Hospital/ Centre/ Nursing Home directly on behalf of the patient. No payment will be made to individual accounts.

5. Bills issued by the Hospital/ Centre/ Nursing Home should be submitted along with this application.

6. All dispersals will be at the sole and final discretion of Neurology Foundation Trustees only.