

APPLICATION FORM FOR ASSISTANCE
(Healthcare)

(स्वास्थ्य देखभाल)



APPLICATION No. : K/0717/0852 APPLICATION DATE : 04.09.17

NAME of APPLICANT : AMAR KRISHNA ADHIKARI AGE-YEARS : 59 SEX : M

FATHER'S/SPOUSE'S NAME : MADHAB ADHIKARI

PRESENT RESIDENCE ADDRESS : PARCELM POINA, JIBANTALA, SOUTH 24 PARGANAS, 743376, WEST BENGAL

PERMANENT RESIDENCE ADDRESS : AS ABOVE

OCCUPATION : LABOUR

TOTAL ANNUAL INCOME : RS. 1600 x 12 = 19,200/- (Attach Proof of Income)

PAN No. : [Blank]

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): Yes / No

FAMILY DETAILS				
Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
1	AMAR KRISHNA ADHIKARI	59	M	SELF
2	JAYANTI ADHIKARI	59	F	WIFE
3	KARTICK ADHIKARI	28	M	SON
4	NIRMALA ADHIKARI	25	F	DAUGHTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basis/Proof
गरीबी रेशन कार्ड का प्रमाण पत्र (प्रमाण पत्र की साथ प्रती संलग्न करें)	आय वर्ग का प्रमाण पत्र (प्रमाण पत्र की साथ प्रती संलग्न करें)	उपभोग्यता कार्ड (प्रमाण पत्र की साथ प्रती संलग्न करें)	अन्य कोई प्रमाण

"PURPOSE" for REQUESTING ASSISTANCE:

Sr. No.	Medical Reports/Prescriptions Attached
1	DIAGNOSIS - CATARACT - RE
2	SURGERY - RE (SICL-FIOL)

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED

