Department of Social Welfare

APPLICATION FORM FOR FINANCIAL ASISTANCE FOR MEDICAL TREATMENT OF THE AGED

(To be submitted through the District Social Welfare officer concerned)
Incomplete application(s) received after the stipulated date will not be entertained

Last of submission of the application is _____

1. Name of the applicant (in block letter) _____
2. Certificate of the age (attested copy to be attached) If this certificate is not available, approximate age as on the 1st January of applying year duly certified by the Medical Officer may be furnished
3. Name of father/husband/wife _____
4. Is the father/husband alive _____
5. Present address _____
6. Permanent address _____
7. Whether in receipt of any other assistance from government, if so indicate the amount
8. Whether belonging to SC/ST/OBC or not? If reply is in the affirmative, (please attach certificate)
9. Name and address of two responsible persons well known to the applicant who could certify the correctness of his/her statement
    1. _____
    2. _____
10. Whether permanently or partially disabled. Name/Nature of disability
11. Annual income from all sources
12. Are you more than 25 years domiciled in Meghalaya

Date

Signature / Thumb
Impression of the applicant

Place

DECLARATION OF INCOME

Certified that to the best of my knowledge the annual income from all sources of Shri./ Smt. _____ son/daughter of Shri / Smt. _____ Is Rupees _____ _____ per annum

Place :

Date:

Signature of the Issuing Authority

Full name _____

Designation _____

Seal _____

Address in full _____

This certificate may be signed by the Local MLA/MDC/ Local Headman

(CERTIFICATE TO BE SIGNED BY THE MEDICAL OFFICER)

I Director of Medical & Health Office/Medical Officer _____ have examined Shri/Smt._____ aged about _____ and certify that she/he suffering from _____ and advise from Medical treatment/purchase of Medicines amounting to Rs. _____ (Rupees _____) Approximately

Place :

Date:

Signature of the Issuing Authority

Full name _____

Designation _____

Seal _____