Annexure-IV

Application for Financial Assistance under National Policy for Rare Disease, 2021

1.	Name of the Patient (In Block Letters)	
2.	Date of Birth	
3.	Age	
4.	(a) Permanent Address along with Pin Code	
	(b)Address for correspondence	
5.	(a) Email Address (if available)	
	(b) Mobile No. (if available)	
6.	(a) Father's/Mother's name	
	(b) Husband/wife's name	
7.	Applicant's Relationship with the Patient	
8.	Disease from which suffering (Name of the disease)	
9.	Whether the applicant or the person on whom the patient is dependent, is an employee of Central/State Government/ PSUS/Autonomous Bodies/Statutory Bodies	
10.	Amount of Financial Assistance required	
11.	(a) Whether treatment for the same disease has been taken in the past from any government agency/source	
	(b) If so, full details may be given. A copy of the previous prescription may also be attached.	
12.	(a) Whether financial assistance has been received from Prime Minister National Relief Fund (PMNRF) or CM Relief Fund or any other sources for treatment of the same disease.	
	(b) If so, full details may be given.	
13.	Aadhar Card No., if any (Attach self-attested copy) I hereby share my Aadhar Number issued by UIDAI& voluntarily give my consent to link my Aadhar Number with my request for financial assistance under NPRD-2021. I also authorize Ministry of Health & Family Welfare to use my Aadhar card details & identity information for authentication with UIDAI.	

DECLARATION

1. I declare that the information given above is correct and complete in all respect.
2. Though I am covered under PMJAY, the amount of financial assistance required, indicated at Column 10 above, is only for packages not covered under PMJAY.

Signature of the Applicant/Patient

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TO BE FILLED BY THE M.O. IN CHARGE OF THE CASE/HOSPITAL, ETC. WHERE THE PATIENT IS RECEIVING TREATMENT

1. Name of the Patient & Hospital Registration No. :
2. Gist of Reports of important Investigations done :

3. Diagnosis-A Short Note on the present clinical conditions may be indicated :

4. The name of the Hospital where the patient is receiving treatment :
5. Name of the Rare Disease from which patient is suffering:
6. Amount recommended for treatment :
7. Staggered requirement of Fund (Year wise breakup):

8. Item wise break up of expenditure recommended in Column 6

Sr. No.	Name of consumables/medicines required for treatment	Cost (In Rupees)
1		
2		
3		
4		
5		

9. Expenditure incurred on the treatment in the past by government agency source :
10. Certified that the Rare Disease mentioned in Column 5 above is not covered under AB-PMJAY packages.

    OR

    Certified that the patient is covered for benefits under AB-PMJAY. However, the amount recommended for treatment under Column 6 above, is only for packages not covered under PMJAY.

11. Certified that the above demand is within the limit of Rs. 50 Lakh per patient.

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12. **Disclaimer:**

I as a treating physician shall be updating about the progress every 6 months and keep a record of the same to the nodal officer of the COE for the clinical audit purposes. This information will include

a. Date of receiving money :
b. Treatment initiated : Yes/No
   If yes, Date of start of treatment :
c. Intended response present : Yes/ No

d. Disease specific follow up progress :

Signature of the Treating Doctor with Official Seal

Annexure-IV

PATIENT SUMMARY FORM FOR THE COE COMMITTEE
[Rare disease funding support of INR 50 lacs from MOHFW]
(To be filled by the referring physician)

1 Date of Application :
2. Details of the Referring/Treating Physician
   a. Name :
   b. Affiliation :
   c. Phone No :
   d. Email id :
3. Patient's Name :
4. Date of Birth/Age :
5. Father's name :
6. Mother's name :
7. Permanent Address along with Pin Code :
8. Mobile No :
9. Final Diagnosis :
10. Confirmatory test report (put details and attached a copy) :

11. Treatment requested(with duration) & cost of treatment per year :

12. Approved by FDA/EU/DCGI/Others : Yes/No
    (If yes, full details may be given)

13. Brief summary and present condition of the patient :

14. Expected response to therapy based on available literature(Please write briefly) :

Date: _____ Physician's name with signature: _____