The Trained Nurses’ Association of India

FINANCIAL GRANT APPLICATION FORM

Please tick the appropriate column, One member can apply only one at a time

<table>
<thead>
<tr>
<th>Medical Assistance*</th>
<th>Critical Assistance**</th>
<th>Nurses Welfare Grant***</th>
</tr>
</thead>
</table>

A. PERSONAL DETAILS  (Please use BLOCK LETTERS (capital letters) for filling the application form)

1. Name of the applicant Mr./Mrs./Ms.:

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Surname</th>
</tr>
</thead>
</table>

2. TNAI Number :

3. Name of the Patient Mr./Mrs./Ms./Master (If other than applicant):

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Surname</th>
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4. Age:

<table>
<thead>
<tr>
<th>Years</th>
<th>Months</th>
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</thead>
</table>

4. Sex

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

5. Correspondence address:


6. Contact no:

<table>
<thead>
<tr>
<th>Mobile Phone</th>
<th>Residence</th>
</tr>
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7. Email:


B. TREATMENT DETAILS

8. Name of the Hospital:


9. A. Diagnosis


Moving ahead with Commitment and Dedication Since 1908
B. Duration of Illness/ Treatment (Mention the period of illness/ treatment and from whom the treatment taken):

In Hospital:

Outside the Hospital:

10. Treatment*:

*Attach a separate sheet if the given space is not sufficient

11. Total cost of treatment (estimated/incurred) (In Rs.):

12. Family/Personal contribution (In Rs.):

13. Medical reimbursement from Employer (In Rs.):

14. Total family income (In Rs.)/Month

15. Family Details:

<table>
<thead>
<tr>
<th>#</th>
<th>Name of Family Members</th>
<th>Relationship to patient</th>
<th>Age</th>
<th>Occupation</th>
<th>Monthly Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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</tbody>
</table>

* If you don’t have space in the above table, please add the details in an additional sheet.

C. Details regarding financial assistance sought from other NGO/organizations:

<table>
<thead>
<tr>
<th>#</th>
<th>Name of NGO/organization</th>
<th>Applied on</th>
<th>Amount sanctioned or to be considered / OR refused, pending, any other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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</tbody>
</table>

* If you don’t have space in the above table, please add the details in an additional sheet.

D. I declare that the above facts stated/mentioned and particulars given by me are true and correct.

Signature of the applicant

Date:
Documents checklist (photocopies / scans):

MANDATORY DOCUMENTS:
1. Photo identity proof of TNAI Member (Any one from the list below)
   a. Aadhar Card/Voter ID Card/Ration Card
2. Latest Income Certificate
3. Letter from the Employer/ Self declaration (If not working) mentioning whether the he/ she is eligible for any kind of medical assistance.
4. Certification by the TNAI State Branch President/Secretary/ Zonal President or Secretary.

SUPPORTING DOCUMENTS
1. Attach a photocopy of the discharge card/summary/ interim bills/ Final bill/ deposit receipts/ final settlement receipt.
2. If original bills are submitted to TPA/Insurance company, then a letter from Company on their letterhead mentioning the date and giving details: (i) the amount Insured; (ii) amount of original bills submitted; (iii) the amount sanctioned from the Insurance Company; (iv) the amount of original bills and receipts retained by them; (iv) Name and designation of the authorized signatory along with the rubber stamp of the Insurance company.
3. If claim is under process, please attach photocopy of the Mediclaim policy
4. If the treatment is ongoing or yet to commence, please attach a copy of the advised treatment prescribed.

*Medical assistance
   a. 75% of the Monthly bill be paid (Maximum limit of 1,00,000 Rs)

**Critical Assistance
   a. This facility is applicable in case of accident/organ transplantation/ emergency surgeries/ or any other critical condition which needs immediate medical or surgical intervention
   b. One time financial assistance of 1,00,000 Rs

***Nurses Welfare Grant
   a. Provides long term financial assistance required for TNAI members.
   b. Rs.5000/- per month will be provided for TNAI members who are terminally ill or no family/financial support.
Certification by the TNAI State Branch Executive

This is to certify that, Mr/ Ms/ Mrs ...............................................................

..........................................................W/o, S/o, D/o ..........................................................

.......................................................... is eligible to get the Medical Assistance/ Critical Assistance/ Nurses Welfare Grant (tick the appropriate) and also certifying that, the particulars given above are true to the best of my knowledge and belief.

Name:

Designation:

Date:

Seal