KAINKARYA CHARITABLE TRUST
Flat F1, SREYAS, Plot 76, Second Street,
Balaji Nagar, Alwarthiru Nagar,
Chennai 600087. Tamil Nadu

Mob: +91 96000 87618
Email: kainkaryatrust@gmail.com

Application No: M

REQUEST FOR AID FOR MEDICAL EXPENSES

1. Name of the Beneficiary:	
2. Date of Birth:	
3. Gender:	( ) Male ( ) Female ( ) Other
4. *Aadhaar Number:	
5. Name of Illness:	
6. Name and Address of the Hospital taking Treatment: Name of the Pharmacy in case of support for Medicines:	
7. Inpatient ID (if hospitalized):	
8. Name of the Spouse/Parent of the Patient:	
9. Relationship to the Patient:	
10. Residential Address:	
11. *Aadhaar Number:	
12. Occupation Details:	
13. Annual Income:	
14. No. of Dependents:	Adult: Children:
15. Contact Details	Mobile : Email :
16. Amount Required:	Rs.

Payment Details *Hospital/Pharmacy Account Number for Bank Transfer:	Bank Name: Branch: Account Number: IFSC:

*Attach Copies

I, _____ hereby confirm that the details provided above are correct and true to my knowledge. I enclose the required documents as listed below for your favorable consideration.

Date : Signature of the Patient Signature of the Spouse/Parent

For Office Use

	Approved by

Documents Required:

1. Aid Requisition Letter ( ) 2. Aadhaar Copies ( ) 3. Hospital Certificate For Surgery with Cost ( )	4. Hospital Discharge Summary ( ) 5. Hospital/Pharmacy Account Details ( ) 6. Prescription Copy for Medicine Support ( )