

SAMYUKTA GOWDA SARASWATA SABHA

55, Habibullah Road, T.Nagar, Chennai 600 017

ASSISTANCE FOR SEVERELY HANDICAPPED AND OTHER DISADVANTAGED PERSONS

1. Name of Applicant:		M/F		
		Age		
2. Address and contact Telephone No.				
3. Occupation of the Applicant/Guardian If employed, name of the Employer and contact No.				
4. Total Annual Family Income (Proof needed) (Including income from other sources such as interest, dividends, rentals, etc.)				
5. Details of Assets, if any:				
6. <u>Name of family members:</u>				
Name	Date of Birth	Relationship	Is the person earning	If so, annual income Rs.
7. Name of person for whom assistance is needed:		M/F		
		Age		
8. Relationship				
9. Nature of disability:				
10. Degree of disability (as assessed by a specialist)				
11. Treatment Needed (Doctor's recommendation required)				
12. Aids (Hearing aids, artificial limbs, crutches etc. & training) recommended and its cost. Rs.				
13. Are you entitled for any assistance from your employer directly: If yes, the amount of assistance: Rs.				
14. Reason for not able to pay the balance:				
15. Do you have personal medical insurance?				
16. Place where treatment is to be taken/was taken				
17. Expenses incurred on: (with Doctor's counter signature) Hearing aids Artificial limbs Crutches Medicines Others (specify)				
18. Any other information you would like to share:				
I solemnly affirm that all the particulars and information furnished by me in this application are true if at any itime this is found to be wrong, I am bound to refund the assistance.				
Date:		Signature		

RECOMMENDATION BY TWO MEMBERS
(After verification based on the scheme guidelines)

We have verified the applicant's case and have satisfied ourselves with the genuineness and of the information recorded therein. We recommend the case for Sabha's assistance.

----- 1. Name of the recommender: Address: Signature Phone: Date:	----- 2. Name of the recommender: Address: Signature Phone: Date:
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RECOMMENDATIONS OF THE SCREENING COMMITTEE

The person was seen by us on ----- Recommendations: We recommend/do not recommend the request for assistance or We need to have additional information regarding	<div style="border: 2px solid black; padding: 10px; width: 100%;"> Photograph of the handicapped </div>	
----- Dr. H.R. Shanbhogue	----- Dr. Mrs. Sudha Pai	----- Dr. Mrs. Shantha Kamath

Action by the Sabha:

Approved Sanctioned Rs.----- Hon. Secretary Date:	Paid by Cheque No. Dated: For Rs. <div style="text-align: right; margin-top: 20px;"> Manager </div>
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INSTRUCTIONS:

(Read the instructions carefully before filling the application form)

1. **Eligibility:**
 (a) Total family income not exceeding Rs.3,00,000 per annum.
 A proof of gross annual family income should be attached to the application form.
2. **Total Annual Income** means the total of all income of all the members in the family including income from all sources such as interest, dividends, rentals, etc. and before any deduction such as Provident Fund, Insurance Premium , repayment of Loans, Taxes payable etc.
3. Details of Assets, if any, and value should be furnished.
4. **Treatment taken/to be taken:** A certificate from the Doctor/Hospital/Institution where the treatment /training was taken/to be taken and indicating the actual cost of treatment/training/aids incurred/estimated.
5. The Sabha reserves the right to reject any application or to stop/withdraw the assistance without assigning any reason.
6. The Scheme is limited to SGS Sabha Members and their dependents who are residing within the City limits of Chennai