ROTA FOUNDATION

Reach Out to All

Section 8 License Number: 176331

80G Registered

NITI AAYOG Darpan ID: WB/2026/1001219

MEDICAL ASSISTANCE APPLICATION FORM

Application No.: _____ Date: ____ / ____ / ____

1. PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female ☐ Other

National ID / Passport No.: _____

Mobile Number: _____

Email Address: _____

Current Address: _____

_____

2. MEDICAL INFORMATION

Name of Hospital / Clinic: _____

Treating Doctor: _____

Diagnosis / Medical Condition: _____

_____

Required Treatment / Procedure: _____

_____

Estimated Treatment Cost: _____ Amount Requested: _____

Has treatment already started? ☐ Yes ☐ No If Yes, Date Started: _____

3. FINANCIAL INFORMATION

Monthly Household Income: _____

Do you have Medical Insurance? ☐ Yes ☐ No

If Yes, Name of Insurance Provider: _____

Insurance Coverage Amount (if applicable): _____

4. DOCUMENTS ATTACHED (Please tick)

☐ National ID ☐ Medical Report / Diagnosis ☐ Prescription / Treatment Plan ☐ Cost Estimate from Hospital

☐ Hospital Letter ☐ Income Certificate ☐ Insurance Documents (if applicable) ☐ Bank Details

☐ Other (Please specify): _____

5. DECLARATION

I declare that all information provided is true and complete. I authorize ROTA Foundation to verify the information if necessary.

Applicant / Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

6. FOR OFFICE USE ONLY

Application Received By: _____ Date: _____

Documents Verified: ☐ Yes ☐ No Field Verification: ☐ Yes ☐ No

Committee Decision: ☐ Approved ☐ Rejected ☐ Pending Date: _____

Approved Amount: _____ Officer Signature: _____

Remarks: _____

_____

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