2.3 Application Form for Public Assistance

Assistance / Tuberculosis Assistance / Cancer Assistance / Leprosy / Kidney Disease

District:…………………………………………….......
Divisional Secretariat Division: ....
Grama Niladhari Division ....
Office Number ....

1. Applicant’s full name: ....
2. Applicant’s address: ....
3. Telephone number: ....
4. Applicant’s age: .... Gender: Female / Male .... Marital status: Married / Unmarried ....
5. If the applicant is requesting medical assistance, is the treatment **outpatient** or **inpatient**? ....
6. Medical certificate number, date of issue, and validity period: ....
7. If requesting public assistance, specify **for what purpose**: ....
8. Details of the applicant’s dependents: ....

Serial Number	Name	Relationship	Birthdate	Age

09. Details of the applicant’s children/closest relatives

Serial Number	Name	Relationship	Birthdate	Age

10. Applicant’s occupation .... Monthly income ....

11. Is the applicant a beneficiary of any prosperity allowance? If so, value
    ....
12. Are you currently receiving any aid? .... If so, value
    ....
13. The post office convenient for receiving the fund
    ....
14. If you are unable to go to the post office due to illness or disability, the name of the representative who will go on your behalf
    ....
    Address ....
    ID card number ....
    Signature ....

I certify that the above-mentioned details are correct.

....

Date   Applicant's signature

Grama Niladhari Report

1. **Applicant's health condition** (specifically mention if there are any physical disabilities)
   ....
   ....
2. **Is the applicant able to engage in employment?**
   ....
   If so, provide details of the type of employment
   ....
3. **Monthly income of the applicant's family as certified by the Grama Niladhari**
4. **Reason for recommending a public assistance allowance**
   ....
   ....
   ....

I **recommend / do not recommend** the public assistance allowance.

....

Date   Grama Niladhari's Signature

Social Services Officer's Report

I have personally **examined / not examined** the individual. My observations and recommendations are as follows:
....
....
....
I **recommend / do not recommend** the public assistance funds.

.... ……………………………………..
Date Social Services Officer's Signature

Approved

From the date ...., I approve/do not approve payment to the applicant only, or to the applicant and dependents, at a rate of .... per month.

....
Date Divisional Assistant Secretary /Assistant Divisional Secretary

MEDICAL CERTIFICATE
KIDNEY DISEASE ASSISTANCE
MINISTRY OF PRIMARY INDUSTRIES AND SOCIAL EMPOWERMENT

1. Patient’s Name: ....
2. Age: ....
3. Gender (Female/Male): ....
4. Address: ....
5. Clinic Address: ....

Ward Number: ....   Clinic Number: ....

I hereby declare that I am suffering from kidney disease. I have not previously applied for kidney disease assistance through any other institution. I understand and acknowledge that if any assistance has previously been claimed without the knowledge of the officer issuing the medical certificate, or if I fail to regularly attend clinic appointments, the assistance I receive may be stopped without prior notice, and under no circumstances will any previously received assistance be refunded to me.

Patient's Signature

……………………………….

This is to Certify that,

Rev/Mr/Mrs/Miss……………………………………………………….. of ……………………….. is Suffering Form Kidney Disease And is Taking Regular Treatment At This Institution As An Indoor/Outdoor Patient.

A. Egfr ☐
B. Dialysing Patients ☐
C. Dialysing Commenced on ☐

6. I Recommended that he/she be given Assistance from the Month ………………………………….

………………………………   ………………………………

Date

Nephrologists/Consultant
Consultant V.P/Medical Officer

Medical Officer(it clinic records indicate that nephrologists/consultant V.P has diagnosed him/her as a kidney patient and following treatment for more than 03 month