

Medical Assistance Application Form

District:

Divisional Secretary Division:

Grama Niladhari Division

Office Number

1. Full name of the applicant:
2. Address of the applicant:
3. Telephone number:
4. Age of the applicant: Gender (Female/Male): Marital status (Married/Unmarried):
5. Occupation and monthly income:
6. Name, address, and telephone number of the guardian:
7. Monthly family income:
8.

Serial No	Name	kinship	Birthdate	Age

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

Serial No	Name	kinship	Birthdate	Age

10. Applicant's occupation Monthly income
.....
11. Is the applicant a beneficiary of Samurdhi? If so, value
.....
12. Are you currently receiving any financial assistance? If so, value
.....

13. The post office convenient for receiving the assistance money

14. If you are unable to go to the post office due to illness or disability, the name of the representative sent for this purpose:
 Name
 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** (if there are any physical disabilities, please specify):

 ..
2. **Is the applicant able to engage in employment?**

 If yes, provide details of the type of work suitable:

3. **Monthly income of the applicant's family as certified by the Grama Niladhari:**

4. **Reasons 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 inspected / not inspected. My observations and recommendations are as follows:

.....
.....
.....

I recommend / do not recommend public assistance funds.

.....
Date

.....
Social Service Officer's Signature

I approve.

From the date of payment of Rs. per month is approved/not approved for the applicant only / for the applicant and dependents.

.....
Date

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

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

1. Name of the patient
2. Age
3. Gender (Female/Male)
4. Address
5. Address of the clinic

Plot Number

Clinic Number

I hereby declare that I am suffering from a kidney disease. I have not previously applied for kidney disease assistance through any other institution. I also understand that if I have previously applied for such assistance without the knowledge of the officer issuing the final medical certificate, or if I fail to attend clinic sessions regularly, the assistance payment granted to me may be discontinued without prior notice. I further acknowledge that, under no circumstances, will I be entitled to receive such assistance payments again.

.....

Patient's signature

6. 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

7. I Recommended that He/She be given Assistance From 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

