OCA FOUNDATION

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ONCOLOGY CARE ASSOCIATES FOUNDATION

Application Form for Financial Grant

Form No.:

Guidelines

- This application form is FREE and no payment whatsoever should be made for procuring it.
- Please ensure that all the requested documents are enclosed with this form. INCOMPLETE application forms will be REJECTED. A NEW FORM WILL NOT BE GIVEN IN CASE OF ANY ERROR IN FILLING UP THIS FORM.
- Contact person has to be the patient's immediate family member (father / mother / husband / wife / son / daughter / brother / sister) OR self, above 18 years only. The contact person should be available for all queries.
- Applicants are hereby informed that a very serious view would be taken if any information given / submitted is found to be false or manipulated with an intention to mislead OCA Foundation (OCA).
- Submitting a completed application form to the OCA office does not guarantee financial assistance. The decision of OCA will be final and you will be informed accordingly by the hospital.
- Please DO NOT enclose original documents with this application form. This application form has to be submitted in original only.
- OCA encourages all patients to apply for all Govt. grants like Prime Minister's National Relief Fund, Chief Minister's Fund etc.

PLEASE USE BLOCK LETTERS FOR FILLING THE APPLICATION FORM		
Name of the Patient: Mr. / Mrs. / Miss / Mast.		Photo
Hospital - Case No. / Medical Registration No.		
Date of Birth:	DD / MM / YYYY	
Gender:	Male ☐ / Female ☐ (Tick the appropriate Box)	
Aadhar Card No:		
Permanent Address:		
	City: State: Pin-code:	
Address and telephone number for correspondence in city of treatment		
	City: State: Pin-code:	
Name of Contact Person:		
Tel No:		
Tel No: (at least one land line number is mandatory)	Mobile No. of the Patient: Landline with Std. code: The Mobile No. must remain in use throughout the treatment period	
Occupation of Patient (Tick one):	Govt./ Pvt./ Farmer / Laborer / Self Employed / Professional / Student / Un-employed / Housewife / Child	
If student:	Name of Institute: City: State:	
	Currently Studying in Std / Year:	
If Working/Business	Name of Institute: City: State:	
	Designation: Employed since: -	

Language of Communication: 1. _____ 2. _____ 3. _____

Is the patient covered under medical insurance scheme like Mediclaim?	Yes / No

Hospital Details

Type of Cancer:	
Name of the Hospital and City:	
Date of Registration at the Hospital	
Category of the Patient (As per Hospital classification)	
Estimated treatment expenses (As per cost certificate):	Rs.
Has the patient incurred expenses towards this treatment?	Yes / No

If Yes, Amount incurred Rs. _____ (Patient should submit copies of bills / cash memos)	How was it incurred?
Family's contribution towards future treatment expenses:	
Amount in Patient's Hospital account on the date of application expenses: Rs.	

Family Details

Sr.	Name of Patient & Immediate Family Members	Relationship to the patient	Age	Occupation	Monthly Income (Rs.)	Income Certificate enclosed Yes / No
Total family income (annual): Rs.						

Please Give Details Regarding Financial Assistance Sought from other Trusts / Organization:			
Sr.	Name of Trust / Organization	Applied on	Amt. Sanctioned or to be considered / or refunded, Pending any other

TO BE FILLED IN BY TREATING DOCTOR							
1	Name of the Patient:	Mr./Mrs./Miss./Master					
2	Diagnosis:						
3	ICD Code:				Stage of Disease:		
4	Treatment Protocol:						
5	Risk Category:	Standard Risk / Intermediate Risk / High Risk / Good Risk / Low Risk (Tick One)					
6	Intent of treatment:	Curative / Palliative (Tick One)					
7	Histopathology Details:						
8	Expected 5 Yrs. Survival Rate %:						
9	Estimated Duration of treatment:						
10	Estimated treatment Expenses: (Please indicate total cost)	Rs.					
11	Time line for treatment expenses	0-3 months	4-6 months	7-9 months	10-12 months	>12 months	Total (Rs.)
12	Compliance & Regularity of Patient:	Regular / Irregular (Tick One)					

Break up Expenses	
Chemotherapy: (Rs.)	
Surgery: (Rs.)	
Radiotherapy: (Rs.)	
Prosthesis: (Rs.)	
Supportive Care: (Rs.)	
Bone Marrow Transplant: (Rs.)	
Any other: (Rs.)	
N. B. Kindly ensure that the Total of Break up Expenses equals the Estimated treatment expenses as stated above	

DOCTOR'S NOTE		
DOCTOR'S DETAILS		
Name of Doctor:		
Contact Nos.	Landline:	Mobile:
Email Address:		
Registration No. of the Doctor:		
Name of Hospital:		Stamp:
Signature:		

PATIENT'S / GUARDIANS CONSENT FORM

I am applying for financial aid or treatment of cancer for myself / my child from OCA Foundation.
I DECLARE THAT THE PARTICULARS AND INFORMATION CONTAINED IN THIS APPLICATION ARE COMPLETE AND CORRECT.
I AM ALSO AWARE THAT SERIOUS ACTION TO BE TAKEN IF ANY OF THE ABOVE PARTICULARS OR INFORMATION IS FOUND TO BE FALSE OR MANIPULATED.

I have no objection to the usage of my / my child's image, name and other details on the website of OCA and in our brochure, pamphlets, advertisement of any kind, publication or any other form of media.

Yours faithfully,

_____

(Signature of patient / Guardian ONLY In case the applicant Is a minor)

_____ _____

(Full Name of Patient) (Full Name of Contact Person)

(In case of thumb Impression, please get It attested by an authorized person - Right thumb for women and Left thumb for men)

COMMENTS BY MEDICAL SOCIAL WORKER

_____

(Signature / Full name of medical social worker)

Date: Place: Stamp of Hospital

COMMENTS BY DUE DILIGENCE TEAM OF OCA FOUNDATION (FOR USE BY OCA ONLY)

Date: Signature-1 Signature-2 Signature-3

LIST OF ENCLOSURES	
1. Hospital Registration Page	2. Ration Card OR BPL Card OR Original Affidavit
3. Cost Certificate with complete break-up on Hospital Letter Head.	4. Income Certificate OR Salary Slip / Employer's Salary Certificate (for each earning member of the family).
5. Aadhar Card	6. Any other