

Application for Financial Assistance

Covered under CSR Schedule VII -Item 1 (i) (Promoting preventive health care)

To

Date: 30/08/24

Birewar Foundation Trust

503-504, Keshava, Bandra Kurla Complex

Mumbai 400051

Subject: Application for financial assistance for Medical Treatment

Dear Trustees,

We request financial assistance for our child who have been enrolled for medical treatment with EN1 Neuro Services. (Please read the rules in the annexure).

Name of the Child	Prerna Anil Shinde		
Age (Yrs)	20 yrs 3 mos	Sex (M/F)	☒
Parents Name	Sunita Shinde	Family Income	
		(Rs Lakh/Year)	
Address			
email			
Check to be Issued to	9967441218		

Documents Attached	Received / Tick Mark	Signature by Recipient	Name Of Recipient (BFT)
Self-attested copy of Pan Card	☒	} Already given	
Aadhaar Card (one of the Parents)	☒		
Cancelled Cheque	☒		
Income Proof Statement.	☒		

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Parents Signature <i>१३ नी.ता.श्री</i>	Sign :	Date <i>30/08/24</i>
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Recommended Treatment (To be filled by EN1 Neuro Medical Professionals):

Diagnosis(Tick)	Tickmark	Duration (months)	Cost (Rs/month)	Total Cost (Rs)
Autism Spectrum Disorder				
Cerebral Palsy/DD				
ADHD				
LD				
Epilepsy	✓	3m :	3500/- mths.	
Neurological Disorders	✓		10500/- x 3 mths.	
Any				
Other				
Hisartimlaton				
Describe:				
Type of Intervention				
Team (Names)				
Number of sessions/week				
Comment:				
Financial Aid Recommended		35007 - mths	Total Rs.	10500
Treatment-Provider's Signature		<i>Neeleat</i>	Date:	30/8/24
Treatment-Provider's Name		Dr Neeleat	Title:	Neurologist

(Sept/Oct/ Nov-24)

Birewar Foundation Trust

Financial Aid Sanction Form

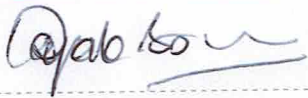
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Dear Sir / Madam:

We are happy sanction your financial aid as follows:

Name of the Patient	Prema Anil Shinde	
Name of the Disorder		Total Rs : 3500 / —

Approval Signatures

Trustee 1 Signature		Date	3/9/2024
Trustee 1 Name	Dr. Deepak Birewar.		
Trustee 2 Signature		Date	
Trustee 2 Name	Shobana Birewar.		