Application for Financial Assistance

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

To

Birewar Foundation Trust

503-504,Keshava, Bandra Kurla Complex

Mumbai 400051

Date: 30/08/24

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: Prema Anil Shinde	
Age (Yrs) 20 yr 3mos	Sex (M/F) ✓
Parents Name Sunita Shinde	Family Income (Rs Lakh/Year)
Address	
email	Phone Number 9967441218
Check to be Issued to	

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	Sign :	Date	30/08/24
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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			3500/- mnths.	
Epilepsy ✓	✓	3m :	10500/- x 3 mn.	
Neurological Disorders				
Any Other Hisartimlaton				
Describe: Type of Intervention Team (Names) Number of sessions/week Comment:				
Financial Aid Recommended	3500/- mnth		Total Rs.	10500
Treatment-Provider's Signature	Neelkant .		Date:	30/8/24
Treatment-Provider's Name	Dr Neelanant .		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.		