Application for Financial Assistance

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

cpCTo

Birewar Foundation Trust

503-504,Keshava, Bandra Kurla Complex

Mumbai 400051

Date: 10/9/25

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	→ Arya Vijay Shinde.		
Age (Yrs)	→ 13 years	Sex (M/F) → female.	
Parents Name	→ Vijay Shinde.	Family Income (Rs Lakh/Year) →	—
Address	Siddique Chowl, Room No-6, Sundar Bagh. Kamani. Kurla (W) Mumbai 70.		
email →		Phone Number → 8097732767.	
Check to be Issued to	———		

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

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Parents Signature	Sign :	Date	

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/-	10500/-
Neurological Disorders				
Any Other Hisartimlaton				
Describe: Type of Intervention Team (Names) Number of sessions/week Comment:				
Financial Aid Recommended	10500/-		Total Rs.	10500/-
Treatment-Provider's Signature	Navneet		Date:	11/9/25
Treatment-Provider's Name	Dr Neelam Naik		Title:	Ped. Neurologist.

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 Child		
Name of the Disorder		Total Rs :

The following documents need to be submitted for the **reimbursement** monthly

(After completion of one month of therapy)

1. Self-attested receipt copy of first two months payment made by the parents.
2. A single page objective report by the therapist describing the regularity of the child, parent participation, improvement in the child.
3. Parent testimonial regarding therapy.

Approval Signatures

Trustee 1 Signature	Sign done	Date	
Trustee 1 Name			
Trustee 2 Signature		Date	
Trustee 2 Name			

Birewar Foundation Trust

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Disbursement Record

Rs. Paid	Date	Check Number	Signature of Donee	Name of Donee

Disbursement Receipt Record

Documents Required	Received (Tick Mark)	Signature by Recipient	Name Of Recipient (BFT)
Self-attested receipt copy of first two months payment			
objective report by the therapist			
Parent testimonial regarding therapy			

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Annexure

1. After enrolling for the treatment, parents will pay full amount for the first month of therapy.
2. Financial assistance will be sanctioned at the beginning of treatment for a maximum period of 3 months. The reimbursement will be monthly only after parents have regularly completed first month of therapy & made the payment for next month for consecutive 3 months. The need for therapy will be reviewed after 3 months of therapy.
3. Amount sanctioned will depend on cost of treatment, and the monthly income of the family. The trust will provide help to those families whose gross income is 6 Lakhs or less per annum.