Application for Financial Assistance

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

To

Date: 13/4/23

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)	18.10yrs	Sex (M/F)	Female
Parents Name	Sunita shinde	Family Income (Rs Lakh/Year)	
Address	Rajesh Compound Room-1 Babu Govind Rathod Chawl Dahisar - 400022		
email		Phone Number	9967441218
Check to be Issued to	Sunita Anil shinde		

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	
रेणुका नाईक			

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	✓	3 month	3500/-	10500/-
Neurological Disorders				
Any Other Hisartimlaton				
Describe: Type of Intervention Team (Names) Number of sessions/week Comment:				
Financial Aid Recommended	Needaik		Total Rs.	10500/-
Treatment-Provider's Signature			Date:	12/4/23
Treatment-Provider's Name	Dr. Neeta Naik		Title:	

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	Prerna Anil Shinde	
Name of the Disorder	Epilepsy	Total Rs : 10,500/-

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 12/4/2023
Trustee 1 Name	DR. Deepak Birewar	
Trustee 2 Signature		Date 12/4/23
Trustee 2 Name	Shobana Birewar	

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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.