অসম চৰকাৰ
GOVERNMENT OF ASSAM

SUHRID

Application to the Deputy Commissioner _____ for availing financial assistance for **HEALTH** Purpose under MLA Area Development Fund (SUHRID), Govt. of Assam.

L.A.C :

(Fill all fields in BLOCK LETTERS) *(Fields marked as * are mandatory)*

1.Name of Patient:*

2. Date of Birth:* D D M M Y Y Y Y 3.Gender:* ☐Male ☐Female ☐Others

4.(a) Guardian's Name:* _____ 4.(b) Guardian's Occupation:* _____

4.(c) Relationship: * *(Tick One)* Father / Mother / Spouse / Son / Daughter / Uncle / Aunt / Brother / Sister / Grandfather / Grandmother / Others *(with Patient)*

5. ADDRESS IN FULL: *(See Overleaf for Instructions on Address fields)*

(a) District :* _____ (b) Circle:* _____

(FOR URBAN AREA)
(c) Municipality (MC/MB/TC):* _____
(d) Ward : _____

(FOR RURAL AREA)
(e) Block:* _____ (f) G.P. / T.B:* _____
(g) Village : _____

(h) Post Office: _____ (i) Police Station : _____

(j) Locality:* _____ (k) PIN Code:*

Photo *

6.Caste:* ☐General ☐ST(P) ☐ST(H) ☐SC ☐OBC ☐MOBC 7.Community: ☐Minority ☐Tea Tribes

8.Religion:* ☐Hindu ☐Muslim ☐Christian ☐Sikh ☐Buddhist ☐Jain ☐Others 9.Mobile: *

10.BANK AND PAN DETAILS:

(a) Bank Name:* _____ (b) Branch:* _____

(c) Branch IFSC : *

(d) Account No.:*

(e) Account Holder's Name:* _____ (f) PAN No.:

11. MEDICAL DETAILS:

(a) Type of Disease/Medical Condition: * ☐Accident ☐Burns ☐Cancer ☐Cardiovascular ☐Kidney ☐Liver ☐Neonatal ☐Neurological ☐Others

(b) Disease Name *(if applicable)*: _____

(c) Name & Address of the Hospital for treatment*: _____

(d) Suffering Since: * D D M M Y Y Y Y

(e) Currently Undergoing Treatment?:* ☐YES ☐NO *(If YES, then please enclose a copy of Doctor's Prescription with this application)*

12. Whether any Family Member of the Beneficiary is a Government Employee:* ☐YES ☐NO

13. Whether any Govt. Aid is received earlier under any Head? (If Yes, please give details)* ☐YES ☐NO

_____

14.(a) ID Proof Type:* _____ (b) ID Number:* _____ (c) Name on ID:* _____

15. Enrolled in Aadhaar? ☐YES ☐NO (If YES, provide Aadhaar Number:)

16. Signature of the Doctor (under whom the patient has undergone treatment) with Seal*	17. Recommendation of the MLA concerned with Seal*
Date: Seal & Signature of Doctor	Amount Recommended: ₹ _____ Date: Seal & Signature of MLA

Declaration: (1) I hereby declare that the information provided above is true to the best of my knowledge.

(2) I hereby allow the usage of my Aadhaar Data for official purposes.

Date* :-

Place*:-

Signature/Thumb Impression of patient*

INSTRUCTIONS FOR FILLING UP THE SUHRID FORM FOR MEDICAL PURPOSE

- **All Form Fields marked as star (*) are mandatory.**
- **All Form Fields must be filled in BLOCK LETTERS with a Blue/Black Ballpoint Pen.**
- **Please refer to the table below for instructions on how to fill some specific fields in the form:**

<table>
<tr><th>Field No.</th><th>Details</th></tr>
<tr><td>5.</td><td>For URBAN Area, “Municipality” is a mandatory field.
[M.C = Municipal Corporation, M.B = Municipality Board, T.C = Town Committee]
For RURAL Area, “Block” and “G.P. / T.B.” are mandatory fields.
[G.P. = Gram Panchayat, T.B. = Traditional Local Body]
In case of 6th Schedule Districts, T.B. exists instead of G.P.
Traditional Local Body can be Autonomous Council Constituency, Autonomous District Council, VCDC, Village Development Committee, or Territorial Council.</td></tr>
<tr><td>7.</td><td>Community is optional. Only select an option if the Patient belongs to one of the given communities.</td></tr>
<tr><td>9.</td><td>10-digit Valid and Active Indian Mobile Number (for Contact/SMS Alerts)</td></tr>
<tr><td>10. (a)</td><td>The Bank Account must be in one of Nationalised Banks or Regional Rural Banks or Assam Cooperative Apex Bank.</td></tr>
<tr><td>10. (e)</td><td>In case of Joint Bank Account, the names of both the persons should be filled in the field for “Account Holder’s Name”.</td></tr>
<tr><td>13.</td><td>If the Patient has received any Govt. Aid earlier, then the details of the Scheme/Head under which the aid was received must be specified in the space below point 13.</td></tr>
<tr><td>14.</td><td>List of Documents that serve as Valid ID Proof:
<table>
<tr><td>PAN Card</td><td colspan="2">Passport</td></tr>
<tr><td>Voter ID</td><td>Driving License</td><td>NREGA Job Card</td></tr>
<tr><td colspan="3">Photo ID issued by Recognized Educational Institution</td></tr>
<tr><td colspan="3">Certificate of Identity having photo issued by Gazetted Officer</td></tr>
<tr><td colspan="3">Address Card having Name and Photo issued by Department of Posts</td></tr>
</table>
In case the beneficiary is a minor, ID Proof of Guardian may be provided if there is no ID Proof of the minor.</td></tr>
</table>

GENERAL RULES FOR SUHRID BENEFICIARIES UNDER MEDICAL PURPOSE

1. Only one beneficiary may be selected from a particular family in one financial year.
2. Any benefit under the Scheme should not be repeated to the same beneficiary in subsequent years.
3. The beneficiary should neither be from the MLA’s Family nor his/her relatives nor any Govt. employee or his/her dependents.
4. In case the patient (beneficiary) is an infant/invalid, a joint account with the parent/guardian may be opened and the benefit under the scheme will be transferred to the beneficiary’s Bank Account.
5. Hospitals recognized under Assam Clinical Establishment Act will be considered over and above Govt. Hospitals.

(FOR HON'BLE MLA'S RECORD)

Financial Assistance for **Medical** Purpose under MLA Area Development Fund (SUHRID), Govt. of Assam

1. Beneficiary's Name: _____
2. Guardian's Name: _____

   Relationship with Beneficiary: (*Tick One*)

   Father/Mother/Spouse/Son/Daughter/Uncle/Aunt/Brother/Sister/Grandfather/Grandmother/Others
3. Address: _____
4. Type of Disease/Medical Condition: _____
5. Disease Name (if applicable): _____
6. Amount Recommended: ₹ _____
7. Date of Recommendation: _____