Dr. Amedkar Foundation
(Revised on 15.01.2018)

The objectives of "Dr. Ambedkar Medical Aid Scheme" is to extend medical aid grant to the patients belongs to the Scheduled Castes and Scheduled Tribes suffering from serious ailments requiring surgery of Kidney, Heart, Liver, Cancer and Brain or any other life threatening diseases including organ transplant and spinal surgery, whose annual family income is not more than Rs.3,00,000/- (Rupees Three Lakhs) The Scheme will be implemented through the following Hospitals.

(i) All India of Medical Sciences (AIIMS), New Delhi and AIIMS in other States.
(ii) Sanjay Gandhi Post Graduate Institute, Lucknow, Uttar Pradesh.
(iii) Patna Medical College Hospital, Patna, Bihar.
(iv) Jabalpur Hospital and Research Centre, Jabalpur, Madhya Pradesh.
(v) B. Barua cancer Institute, Guwahati, Assam.
(vi) Birla Heart Foundation, Kolkata, West Bengal.
(vii) Kalinga Hospital Ltd., Chandrashekharpur, Bhubaneswar, Orissa.
(viii) Tata Cancer Research Institute, Mumbai, Maharashtra.
(ix) Nizam Institute of Medical Sciences, Hyderabad, Andhra Pradesh.
(x) The Voluntary Health Serviced, Chennai.
(xi) All CGHS approved Hospitals as revised from time to time by the Ministry of Health & Family Welfare, Government of India.
(xii) All State Government Medical Colleges attached Hospitals even if not included under CGHS Scheme.
(xiii) All State Hospitals.
(xiv) All Hospitals recognized by State Government.
(xv) All Hospitals fully funded by either the Central Government or the State Government.
(xvi) All Government Hospitals in District Headquarters/ major towns where surgery or treatment facility for Kidney, Heart, Liver, Cancer and Brain or any other life threatening disease including organ transplant and spinal surgery is available.
(xvii) Any other hospital, which the Chairman of the Foundation is convinced that the relevant case is justified under facts and exceptional Circumstances.

2. ELIGIBILITY

(i) The applicant shall belong to Scheduled Castes and Scheduled Tribes Community.
(ii) Annual family income shall not exceed Rs. 3,00,000/-(Rupees Three Lakhs).
(iii) The Scheme covers major ailments which need surgery such as for Kidney, Heart, Liver, Cancer and Brain or any other life threatening disease including organ transplant and spinal surgery

3. HOW TO APPLY

3.1 The applicant shall apply for medical aid in the prescribed application form or on plain paper as per details in the prescribed Performa available in DAF Website. The application format is attached as **Annexure-I.** The application must be submitted along with the self-certified copies of (i) the caste certificate, (ii) income certificate, (iii) ration card/ aadhaar card and (iv) estimated cost of the surgery duly certified by the Medical Superintendent of the Hospital (as at **Annexur-II**).

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3.2 The duly filled in form should reach the **Director, Dr. Ambedkar Foundation, 15, Janpath, New Delhi,** at least 15 days before the date of surgery.

4. **DISBURSEMENT**

4.1 100% of the estimated cost of the surgery will be directly released to the concerned Hospital with a maximum ceiling limit as indicated in the following table in each case, in the form of through RTGS/NEFT/DD.

Heart Surgery	Rs. 1.25 lakh
Kidney Surgery/Dialysis	Rs. 3.5 lakh
Brain Surgery-	Rs. 1.5 lakh
Cancer Surgery// Chemotherapy/ Radiotherapy	Rs. 1.75 lakh
Kidney/ Organ Transplant-	Rs. 3.5 lakh
Spinal Surgery-	Rs. 1.00 lakh
Other life threatening diseases	Rs. 1.00 lakh

4.2 The medical aid may be released in one instalment, before surgery, on the condition that Utilization Certificate **(Annexure-IV)** shall be submitted to Dr. Ambedkar Foundation by the Hospital along with final bills on the date of discharge of the patient.

4.3 The medical aid released to the Hospital should be utilized within a period of one month of its release The un-utilized aid/balance amount, if any, shall be returned to the Foundation at the earliest in any case not later than one month after the date of discharge of the patient.

4.4 Medical aid from the Foundation and other sources should not exceed the total estimated cost of the surgery.

4.5 The Estimated Cost certificate to be submitted along with the application should contain the date fixed for the surgical operation.

Documents Required

4.6 The Application Form (Annexure-I attached) or on Plain Paper with the details as per the format and photograph should be accompanied with the following documents / certificates:-

(i) Onginal Estimated Cost certificate duly signed by the Medical Superintendent of the concerned hospital. It should contain the date fixed for the surgical operation.

(ii) Self attested photocopies of the following:

(a) Latest Income Certificate,

(b) Caste Certificate and

(c) The Ration Card/Aadhaar Card of the patient.

(iii) **Documents required for Kidney transplant** i.e Relationship with beneficiary (Form 14, format for the decision of the Authorization Committee Certificate), Details of Donor of Kidney i.e Name, Age, Address, Blood Group, UIDAI No./Aadhaar No. of beneficiary.

(iv) For fast processing transfer of aid / grant amount in the approved cases, the bank details of the hospital (a) Accouhnt no. of the hospital (b) Name of the Account Holder (c) IFSC code may be given/provided with the application.

Other Conditions:

4.7 Medical aid from the Foundation and other sources should not exceed the total estimated cost of the surgery. A certificate in this regard should be obtained from the Medical Superintendet of the concerned Hospital.

4.8 The Estimated Cest Certificate (Annexure-II attached,) accompanied with the application (Annexure-I attaced), should contain the date fixed for the surgical operation.

4.9 Ordinarily, the cases of reimbursement of the expenditure incurred on the surgery / treatment in medical aid are not entertained. However, reimbursement may be considered on merit, if the application was received by DAT at least 15 days before the date of surgery.

4.10 A Self attested photograph of the patient should also be affixed on the Application.

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ANNEXURE

Application form
For Medical Aid under Dr. Ambedkar Medical Aid Scheme
(for SC and ST only)

Self Attested Photo of Patient – passport Size.

1. Name of the Patient :…….
2. Name of Father/Mother/Husbanb/Guardian…….
3. Caste (the patient belongs to)……..
4. Gender (Male /Female/Third gender)……Age……..
5. Residential Address of Patient with Pin Code…….
6. Phone Number with STD Code / Mobile Number and e-mail, if available……
7. UIDAI No. / Aadhaar No. of beneficiary…….
8. Nature of Disease……..
9. Date of Surgery/ Dialysis / Chemotherapy / Radiotherapy…….
10. Documents required for Kidney transplant i.e. Relationship with beneficiary (Form 14, formal for the decisio of the Authorization Committee Certificate)……., Details of Donor of Kidney i.e Name……., Age……., Blood Group……., UIDAI No./Aadhaar No……..Address……
11. Name of the Hospital from where treatment is sought and if the said hospital is covered under the Schem (please mention the details (please see para- 1 of the Scheme)……..
12. Medical Aid required (Estimated Cost Certificate in Original issued by Medical Superintendent or the hospita to be attached)……...
13. Annual Family Income from all sources……..
14. Whether the applicant has taken medical financial assistance or aid from any other sources, if so give details……..
15. **Documents Check:** Self attested certificates of following are attached:

    (i) Caste Certificate : Yes/No
    (ii) Income Certificate : Yes/No
    (iii) Ration Card/Aadhaar Card : Yes/No
    (iv) Annexure-II & III duly filled/signed. : Yes/No

16. It is certified that the information furnished above is true to the best of my knowledge and belief and nothing has been concealed.

    I also undertake to ensure that (a) the Discharge Certificate and (b) Final Original Bills Alongwith the (c) Utilization Certificate (UC) Issued by the Hospital, shall be submitted to Dr. Ambedkar Foundation after my discharge from the hospital.

Signature of the Patient
(Either self /relative etc. or of Legal Guardian in case of Minor)

ANNEXURE

Estimate Certificate (on hospital letter head)
For Medical Aid under Dr. Ambedkar Medical Aid Scheme
(for SCs and STs only)

Ref. No……..... **Date…….....**

1. N.S. No. / Patient No. / Admission No. / C.R. No……
2. Name of the Patient: ……....
3. Name of Father/Mother/Husband/Guardian……
4. Gender (Male / Female)…….Age……..
5. Nature of Disease…….
6. Date of Surgery/ Dialysis / Chemotherapy Radiatherapy……..
7. Amount required for Surgery / Dialysis / Chemotherapy / Radiotherapy……..
8. Whether the Hospital is a Central or State Govt. Hospital or recognized by either Central Govt. Or State Govt. Or is fully funded by either Central Govt. Or State Govt. Or is approved under CGHS Scheme of Central Govt. Or fully funded under the list of hospitals indicated by name under the Dr. Ambedkar Medical Aid Scheme (In support,a copy of the relevant order or notification may be enclosed)……
9. Mandate Form/ Bank details of the Hospital (Annexure – III):…….

I undertake that the Hospital shall prepare (a) discharge certificate (b) final bills (c)Utilization certificate of medical aid granted by Dr. Ambedkar Foundation at the time of discharge of the patient from the Hospital and the same shall be immediately forwarded alongwith the Unutilized Aid if any, to Dr. Ambedkar Foundation.

Signature :-……..

(Medical Superintendent of Hospitai)

Rubber Stamp bearing
Name & Designation.

MANDATE FORM

To

The Director,
Dr. Ambedkar Foundation,
15, Janpath, New Delhi – 110001.

SUBJECT: **ELECTRONIC CLEARING SERVICE (CREDIT CLEARING)/ REAL TIME GROSS SETTLEMENT (RTGS) FACILITY RECEIVING PAYMENTS FOR "DR. AMBEDKAR MEDICAL AID SCHEME".**

DETAILS OF HOSPITAL BANK ACCOUNT:-

NAME OF THE PATIENT	
NAME AND COMPLETE CONTACT ADDRESS OF HOSPITAL	
(i) TELEPHONE NO: **(ii) FAX NO:** **(iii) E- MAIL ID OF HOSPITAL** **(iv) Tel. No. of the contact person for Clarification.**	
NAME OF ACCOUNT HOLDER	
HOSPITAL ACCOUNT NUMBER	
NAME OF THE BANK WITH **(i) COMPLETE ADDRESS /** **(ii) TELEPHONE ADDTESS /** **(iii) E- MAIL ID for clarification if needed.**	
IFSC CODE OF BANK	
MICR CODE OF BANK	
BANK BRANCH CODE NO.	

DATE OF EFFECT:-

I hereby declare that the particulars given above are correct and complete. If the transaction is delayed or not effected at all for of incomplete or incorrect information I would not hold the user institution responsible. I have read the option invitation letter a to discharge responsibility expected of me as a participant under the Scheme.

(.....)
Authorized Signature of the
bearing Name and Designation

Date:

Certified that the particulars furnished above are correct as per our records.

(Authorized Signature of the Bank
With Bank's Stamp) with Name & Designation
Date:

1. Please attach a photocopy of cheque alongwith the verification obtained from the Bank.
2. In case your Bank Branch is presently not "RTGS enabled", then upon its up gradation to "RTGS Enabled" please submit the information again in the above proforma to the Department at earliest.

ANNEXURE

Ref. No. **Date**

Utilization Certificate (on hospital letter head)
Dr. Ambedkar Medical Aid Scheme of
Dr. Ambedkar Foundation (DAF)
(after surgery duly filled and submitted by Hospital to DAF)

1. DAF's Sanction order No. And date :

2. Name of Patient :

3. Gender :

4. Hospital Patient No. / CR No. / N.S. No. /Admission No. :

5. Medical Aid received from DAF / Cheque No., Date & Amount (Rs.), if so. :

6. Medical Aid received from any other sources, if any/ details I.e. No., Date & Date & Amount (Rs.) :

7. Date of Surgery :

8. Date of Discharge :

9. Total Expenditure (in Rs.) incurred on surgery/ Dialysis / Chemotherapy / Radiotherapy :

   (i) Bill No. & Date :
   (ii) Bill Amount (Rs.) :

10. Unutilized Amount (Rs.) and details of Refund to DAF i.e. date, mode etc. :

11. Remarks :

Medical Superintendent / Competent Authority of the Hospital

Rubber Stamp.....