Application for Financial Assistance

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

To

Date: 2/4/25

Birewar Foundation Trust

503-504, Keshava, Bandra Kurla Complex

Mumbai 400051

Subject: Application for financial assistance for Medical Treatment

Dear Trustees,

I request financial assistance medical treatment.

Name of the Patient	Prerna Anil Shinde		
Age (Yrs)	20.10yrs	Sex (M/F)	female
Parents Name		Family Income (Rs Lakh/Year)	60,000/-
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.			

Applicant Signature	Sign :	Date	
सुनीता शिंदे			

Dec 24 to Feb 25

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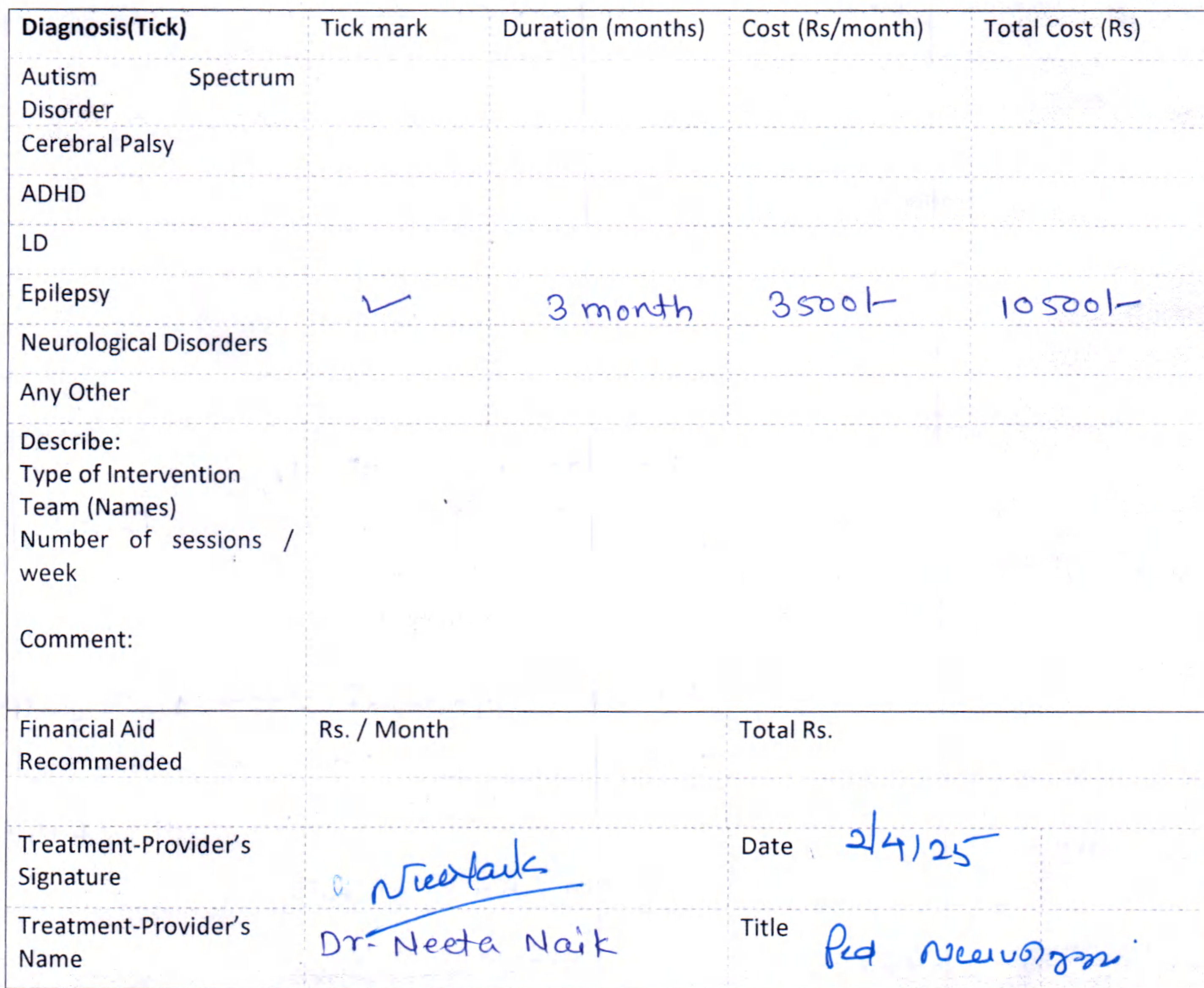
Recommended Treatment (To be filled by EN1 Neuro Medical Professionals):



Diagnosis(Tick)	Tick mark	Duration (months)	Cost (Rs/month)	Total Cost (Rs)
Autism Spectrum Disorder				
Cerebral Palsy				
ADHD				
LD				
Epilepsy	✓	3 month	3500/-	10500/-
Neurological Disorders				
Any Other				
Describe: Type of Intervention Team (Names) Number of sessions / week Comment:				
Financial Aid Recommended	Rs. / Month		Total Rs.	
Treatment-Provider's Signature	[signature]		Date	2/4/25
Treatment-Provider's Name	Dr. Neeta Naik		Title	Ped Neurologist

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 Lakh or less per annum.

Birewar Foundation Trust

Financial Aid Sanction Form

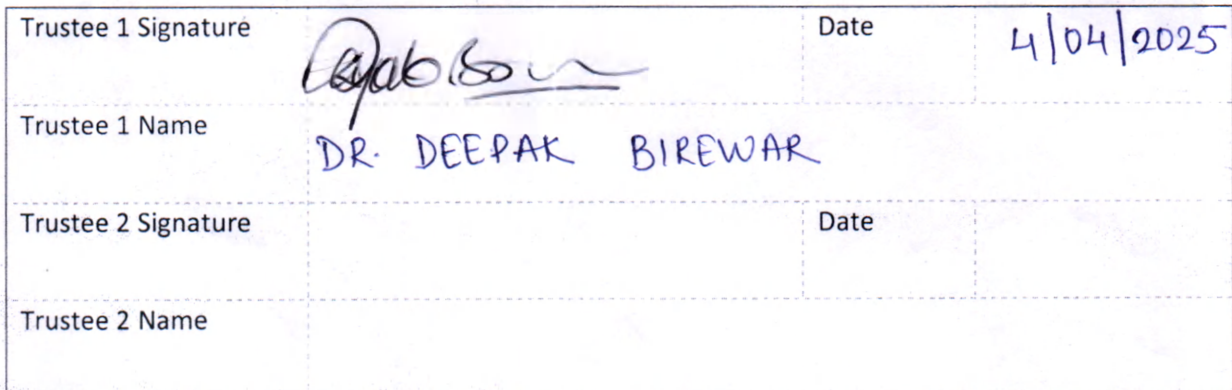
Covered under CSR Schedule VII –Item 1 (i) (Promoting preventive health care)

Dear Sir / Madam:

We are happy sanction your financial aid as follows:

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

Approval Signatures



Trustee 1 Signature		Date	4/04/2025
Trustee 1 Name	DR. DEEPAK BIREWAR		
Trustee 2 Signature		Date	
Trustee 2 Name			

Birewar Foundation Trust

Financial Aid Sanction Form

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Disbursement Record

Rs. Paid	Date	Check Number	Signature	Name of Donee