Kindly send the completed application to the following address:
Department of Public Trustee,
No:02, Bullers Lane, Colombo 07

Department of Public Trustee
Application for Medical Aids

a) Details of the Applicant

1. Full name of the applicant: .....
2. National Identity Card No:.....
3. Address: .....
4. Contact No: .....
5. Occupation: .....
6. Official Address: .....
7. Relationship to the Patient: ..... (Mother/Father/Guardian)

b) Details of the Patient

1. Name of the Patient:.....
2. National Identity Card No:.....
3. Address: .....
4. Birthday: .....
5. Occupation and official Address: .....

   .....
6. Marital Status: .....

c) Details about the Disease

1. Condition of the disease:.....
2. Name of the treating physician: .....
3. Address of the physician: .....

   .....
4. Recommendations of the physician:(A letter from the Physician addressing to the Public Trustee explaining the medical condition of the patient must be submitted.)
5. Name of the hospital where treatment is intended:.....

6. Address of the Hospital:.....

   .....

7. Date of admission to hospital for treatment: .....

8. Expected cost for treatment: (proof must be provided through documents)

d) <u>The manner in which it is intended to cover the expenses</u>

- From the President Fund-.....
- Through the sponsors-.....
- Through your own assets- .....
- Through societies and associations-.....
- From the official institution- .....
- Other- .....
- Total- .....

e) <u>Details of the Patient's family</u>

Description	Name	Age Years	Occupation	Employed Institution	Monthly Income
Head of household					
Spouse					
Unmarried siblings/children					

f) <u>Details of the assets owned by you and your family members, and the income derived therefrom (including particulars of immovable and movable property, as well as monetary deposits).</u>

Immovable Properties- Name of the land and extent- Income	Income from the immovable properties	Cash Deposits (Rs.)	Total Income (Rs.)

g) **<u>Details about the previously taken other aids from the Department of Public Trustee.</u>**

- Wheel chairs.....
- Spectacles.....
- Medical Aids .....
- Other .....

h) **<u>As this financial assistance will be paid directly to the relevant hospital or to the institution from which the medical equipment is to be purchased, please provide the name and address of the hospital.</u>**

.....
.....
.....
.....

I hereby certify that the information provided above is true and accurate to the best of my knowledge and that no material information has been concealed. I further acknowledge and confirm that I am fully aware that any financial assistance granted may be withdrawn if any of the information provided is found to be false or misleading.

Date: …….. Signature of the Applicant: .....

Certification by the Grama Niladhari Reference No: ……

I hereby certify that I am well acquainted with the applicant residing at the address stated above and that, to the best of my knowledge, all the information furnished above, including the family's income status, is true and accurate. Accordingly, I recommend that financial assistance be granted to Rev./Mr./Mrs./Miss**.....**, who is suffering from **.....**, to enable him/her to obtain the necessary medical treatment.

Date: …… Signature and
Official seal of the
Grama Niladhari: …….

Recommendation by the Divisional Secretary Reference No: …….

I approve / do not approve the above recommendation made by the Grama Niladhari. I recommend that it is appropriate to provide financial assistance or assistance in kind to the applicant for the purpose of obtaining medical treatment.

Date: …… Signature and
Official seal of the
Divisional Secretary: …….

For official purposes only

Deputy Public Trustee

In accordance with the objectives of the ..... Trust/Estate, payments may be made towards medical treatment. During the current year, a sum of Rs. ..... has already been granted under this scheme. A further sum of Rs. ..... may be paid on behalf of the patient. Alternatively, no further payment can be made as the prescribed limit has already been exceeded.

Date: ……. ……..
Trust Officer

Public Trustee

I concur with the observations made by the Trust Officer above. I recommend the payment relating to the request for medical assistance. It is appropriate to submit this matter to the Three-Member Committee for its consideration and recommendation.

Date: ……. ……..
Deputy Public Trustee

Recommendation of the Three-Member Committee (To be used only where applicable.)

We certify that the information provided in the application is correct. As the patient is suffering from ....., We recommend that a sum of Rs. ..... be granted to him/her from the ..... Trust/Estate as financial assistance.

…….	…….	……
(1) Deputy Public Trustee (Chairperson of the Committee)	(2) Deputy Public Trustee (Committee Member)	Trust Officer (Committee Member)

Order of the Public Trustee

In consideration of the information provided in the application and the recommendations set out above, I hereby approve the payment of a sum of Rs. ..... from the relevant Trust/Estate to the applicant who is suffering from the stated medical condition. Alternatively, I do not approve the payment for the reasons stated below.

Date: …… ……..
Public Trustee