Chilya Care Foundation

Being united for a noble cause

Patient data form for 2024

Updated: November / 2024 Date:

Patient Details			
Patient Name:			
Patient Profession:		Age:	
Location:		Village:	
Type of Disease:			
Name of Hospital:			
Patient Admitted:	Yes / No -		

Doctors Opinion	
1st Opinion Dr Name:	
Hospital Name:	
2nd Opinion Dr Name:	
Hospital Name:	

Family and responsible persons details			
Responsible person name:			
Relation with patient:		Contact No:	
No. of family members:			
Total family Income:			

Fund details and Declaration form	
1) I certify that the information on the application form I submitted are true and accurate.	
2) I agree that any false or misleading information will result in a rejection & expulsion of the form.	
3) Patient authorises Chilya Care Foundation to pay hospital bills directly on their behalf.	
Total Estimated Amount:	
Type of Amount required:	Zakat / Lillah -
Patient Signature:	**Patient signature is compulsory**

Approval and Guarantor	
For Zakat	
Approval Mufti name for Zakat:	
Mufti saab contact No:	
For Lillah	
Village Guarantor name for Lillah:	
Guarantor contact No:	

Area Coordinator	
Area Coordinator Name:	

Hospitals Bank Details	
Bank Name:	
Account Name:	
Bank Account No:	
Bank IFS Code:	

Required Documents
1) Estimated operation cost from two Doctors.
2) Current hospital bill.

Criteria, Terms and Condition
1) We will assist Up to 45% of the total case value.
2) A person's assistance will not be repeated for at least a year for the entire family.
3) Will only assist with the current case.
4) The funds will be deposited straight into the hospital's bank account.
5) The hospital chosen for ultimate treatment must be authorized by our team of doctors.
6) Will be given priority on a first-come, first-served basis.
7) No help will be given for Medicine, Reports, or Treatment charges.
8) Has to chose a hospital from the list of hospitals we have for each Treatment.

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