



JSY APPLICATION FORM

Government of Puducherry - Health Department



(Note : To be filled by ANM/Health Worker on Identifying a beneficiary after ensuring that she will be picked up in the Scheme at the earliest, preferably in the First Trimester of the Pregnancy)

Pregnant Mother Tracking Card No.

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Date of filling the Application :/...../20.....

PART I - IDENTIFICATION

A. PHC / CHC Name :																			
B. Sub-Centre Name :																			
1. Applicant's Name : (Pregnant Women)																			
2. Husband's Name :																			
3. Applicant's Address :																			
4. Husband's Occupation:	4.1. Daily Wager / self employed / vagabond / rag-picker / small vendor / others (Please use tick mark) 4.2 If others, please specify:																		
5. Beneficiary of any of these schemes? NMBS/NFBS/NOAPS/Targeted PDS/Antyodaya Anna Yojana / any other social assistance schemes of state or GOI for BPL families / others, etc.	(Please specify and enclose document, if available)																		
6. Possess a BPL Card ?	Yes / No If Yes, BPL Card No. (Copy to be enclosed)																		
7. Applicant's place of living:	Rural / Urban / Urban Slum (Please tick mark)																		
8. Is Beneficiary 19 Years & above	Yes / No																		
9. Order of Present Delivery ?	First / Second / Above 2 (Strike out not applicable)																		
10. Is Beneficiary eligible under JSY?	Yes / No (To be certified by ANM)																		
11. Name of the identified place of Delivery? Please record it in your daily dairy for future monitoring.	(Explain the benefits of delivering at a Govt. Sector Hospital)																		

Verified by ANM/AWW/ASHA etc.

Signature / TI of the Applicant

PART II - DELIVERY

12. Place of Delivery	IGMC&RI / RGGW&CH / CHC / PHC / Private Hospitals. (Please indicate name of CHC / PHC)																		
13. Date of Delivery						(Discharge Slip to be enclosed or to be certified by Medical Officer / Health Worker)													
14. Name of ANM / Health Worker who filled this application	Signature with date									Verified the above facts and found to be correct. Name of M.O. Signature of M.O.&Seal									

PART III - SUMMARY (For sanctioning by the Medical Officer / Authorised Officer)

I have satisfied myself with the facts stated above and as per the norms of JSY recommended / approved to pay a sum of Rs.....to the beneficiary. I have checked the Maternal Card of this beneficiary and found that she has received the desired ANC's and the regular immunisation of the new born.

Signature of the Athorised Medical Officer
Seal with Name, Designation & Centre



MANDATORY FORM

ELECTRONIC CLEARANCE SERVICE (CREDIT CLEARING) / AADHAAR BASED PAYMENT SYSTEM (ABPS) BENEFICIARY FOR RECEIVING PAYMENTS UNDER JANANI SURAKSHA YOJANA SCHEME

A. DETAILS OF ACCOUNT HOLDER

Name of Account Holder :
(As entered in Bank Pass Book)
Complete Contact Address

Aadhaar No. :
(Xerox copy of the Aadhaar Card to be enclosed)

Telephone / Mobile Number / Fax / e-mail :

B. BANK ACCOUNT DETAILS

Bank Name :
:

Branch name with complete address, telephone number and e-mail.

Bank Branch IFSC Code :

Complete Bank Account Number :
(Xerox copy of First Page of Bank Pass Book to be enclosed)

I, hereby authorise Pondicherry State Health Society to credit the amount due and admissible under Janani Suraksha Yojana Scheme to my Bank Account furnished (B) above. I certify that I belong to BPL / SC / ST family. I further certify that I will not raise any objection in future in this regard.

Date:

Signature of Beneficiary

Certified that the particulars furnished above are verified and found to be correct.

Date:

Signature of ANM / LHV / Counsellor