APPLICATION FORM FOR CLAIM OF THIRD INSTALLMENT UNDER PMMVY

Mandatory fields*

1. Name of beneficiary*: ___________________

2. Aadhaar/Identity number of beneficiary*: ___________________

   Identity Proof provided (tick one, as appropriate):
   a) Bank or Post Office photo passbook
   b) Voter ID Card
   c) Ration Card
   d) Kishan Photo Passbook
   e) Passport
   f) Driving License
   g) PAN Card
   h) MGNREGS Job Card
   i) Her husband’s Employee Photo Identity Card issued by the Government or any Public Sector Undertaking;
   j) Any other Photo Identity Card issued by State Government or Union Territory Administrations;
   k) Certificate of identity with photograph issued by a Gazetted Officer on official letterhead;
   l) Health Card issued by Primary Health Centre (PHC) or Government Hospital;
   m) Any other document specified by the State Government or Union Territory Administration

Note: Alternate ID for claiming this instalment will be accepted only in Jammu and Kashmir, Assam and Meghalaya.

3. Date of delivery*: ___________________

4. Did the delivery take place in a Government approved facility*?: Yes No

   a. If yes, Name of Government approved facility ___________________

5. Tick yes, if already registered under the scheme?: Yes No (If no, then fill Form 1-A)(If yes, enclose copy of Acknowledgement Slip)*

6. Gender of Child/Children*:

   a. □ Male □ Female (Please tick)

   In case of multiple births, fill the following:

   b. □ Male □ Female (Please tick) (in case of twins)

   c. □ Male □ Female (Please tick) (in case of triplets)
7. First cycle of Vaccinations given*:
   a. BCG or equivalent/substitute: ☐ Yes ☐ No
   b. OPV or equivalent/substitute: ☐ Yes ☐ No
   c. DPT or equivalent/substitute: ☐ Yes ☐ No
   d. Hepatitis-B or equivalent/substitute: ☐ Yes ☐ No

8. Date of completion of first cycle of vaccinations*: ________________

9. Tick ‘Yes’ if beneficiary reports case of any previous still births: ☐ Yes ☐ No

10. Enclose copies of*:
    a. Child Birth Certificate
    b. MCP card with immunization details

11. Health ID of beneficiary: ____________________________________________
     ____________________________________________

12. Details to be filled Anganwadi Worker / ASHA /ANM

   Anganwadi Centre Name/Approved Health Facility Name: ________________
   Anganwadi Centre Code*: ________________________________
   Village/TownName: _________________________________________
   Village Code*: __________________________________________
   Anganwadi Worker / ASHA /ANM Name*: ______________________
   Post Office Name: _________________________________________
   Project: _________________________________________________
   District*: ______________________________________________
   State/UT*: _____________________________________________

   Date of Claiming 3rd Instalment by beneficiary*: --/--/--
   Date of submission to Supervisor / ANM*: --/--/--
13. Benefits under Janani Suraksha Yojana

i. Did Beneficiary receive incentive under Janani Suraksha Yojana (JSY): YES / NO

ii. If yes, then how much amount was received? ................

13. **Checklist of Documents enclosed:**

<table>
<thead>
<tr>
<th>S.No</th>
<th>Document to be enclosed (photocopy to be enclosed)</th>
<th>Document Enclosed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Y</td>
</tr>
<tr>
<td>1</td>
<td>Aadhaar Card of beneficiary</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>MCP Card with immunisation Details</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Child Birth Certificate</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Acknowledgement Slip</td>
<td></td>
</tr>
</tbody>
</table>

Verification by Supervisor / ANM*

I, Smt. ______________ have verified the information captured in the form and that the form is duly complete.

Signature     Name     Date     Sector Code
Acknowledgement to be given to beneficiary* (by Anganwadi Worker / ASHA /ANM)

Village/Town Name*: __________________________________________

Anganwadi Centre Code*: _______________________________________

Village Code*: ______________________________________________

Anganwadi Worker / ASHA /ANM Name*: __________________________

Post Office Name: ________________________________

Sector Name: _____________________________________________

Project/health Block Name: _________________________________

District*: ________________________________________________

State/UT*: ________________________________________________

Smt.*___________________ (Name) has submitted duly filled Form 1-C along with documents as per checklist on _______ (Date).

Signature  Date  Place

________________________________________________________________________________