

(FILLED UP FORM SHOULD BE SUBMITTED TO AUTHORISED PERSONS ONLY)

Form 1-C

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 installment 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)

d.  Male  Female (Please tick) (in case of quadruplets)

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/Town Name: \_\_\_\_\_

Village Code\*: \_\_\_\_\_

Anganwadi Worker / ASHA / ANM Name\*: \_\_\_\_\_

Post Office Name: \_\_\_\_\_

Project: \_\_\_\_\_

District\*: \_\_\_\_\_

State/UT\*: \_\_\_\_\_

Date of Claiming 3<sup>rd</sup> Instalment by beneficiary\*: -----/-----/-----

Date of submission to Supervisor / ANM\*: -----/-----/-----

**13. Checklist of Documents enclosed:**

S.No	Document to be enclosed (photocopy to be enclosed)	Document Enclosed Yes- Y
1	Aadhaar Card of beneficiary	
2	MCP Card with immunisation Details	
3	Child Birth Certificate	
4	Acknowledgement Slip	

Signature/Thumb Impression \_\_\_\_\_ Date \_\_\_\_\_ Place \_\_\_\_\_

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 \_\_\_\_\_  
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 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 \_\_\_\_\_