



యర్రమాడ ఫౌండేషన్
Yarramada
FOUNDATION

Reviving Hope of Life

YARRAMADA FOUNDATION

Medical Equipment Assistance – Application Checklist & Instructions

Trust Registration
No.: IV/85/2025



Administrative Office:

H.No. 3-7/21, Shiva Sai Ram Colony, Road No.4,
Near SBH Colony Arch, Munaganur,
Hyderabad – 501511, Telangana.



96664 66677



helpline.yf@gmail.com



www.yarramadafoundation.org



DOCUMENT CHECKLIST

Mandatory Documents (Photocopies)



PASSPORT SIZE PHOTO- 1NO

Applicant's & Patient's Photo Identity Proof (Any One)

- Aadhaar Card
- PAN Card
- Voter ID



Address Proof (Any One)

- Aadhaar Card
- Voter ID
- Electricity Bill



White Ration Card (BPL) (if applicable)



Medical Documents

- Doctor's Prescription / Advice Letter
- Hospital Discharge Summary
(if discharged)
- Treating Doctor's Certificate
(for ongoing treatment)



Details of financial assistance received from
or applied for other Trusts/Organizations (if any)



IMPORTANT INSTRUCTIONS

- Medical equipment assistance is available only to **Indian citizens** residing in India.
- Applications may be submitted by:
 - The Patient
 - Patient Attendant / Caregiver
 - Immediate Family Member or Close Relative
 - Government Hospital
 - Primary Health Centre (PHC)
 - Community Health Centre (CHC),
Basti Dawakhana (Mohalla Clinics)
 - Old Age Home
 - Registered Charitable Trust / NGO
- The applicant must be **18 years of age or above**.
- Applications containing **false, incomplete,**
or **misleading information** shall be rejected.
- Medical equipment is provided **free of cost,**
subject to availability.
- Yarramada Foundation has **no agents,**
brokers, or intermediaries. Do not pay any
person for obtaining this service.
- Applications may be submitted in **person** at the
Trust Office or by email to **helpline.yf@gmail.com.**
- Any missing supporting documents must be submitted
within 7 days of notification, failing which the
application may be treated as closed.
- The Foundation reserves the right to request any
additional documents or information whenever necessary.



MEDICAL EQUIPMENT SUPPORT



Medical Equipment	White Ration Card (BPL) Holders	Other Applicants
 Oxygen Concentrator (5 LPM)	FREE TO USE	Temporary use until alternative arrangements are made (subject to availability)
 Bi-PAP Machine	FREE TO USE	Temporary use until alternative arrangements are made (subject to availability)



Refundable Security Deposit

₹15,000 per equipment

Note: The refundable security deposit shall be returned after the equipment is received in
good working condition, subject to inspection by the Foundation.



OXYGEN CYLINDER BACKUP IS MANDATORY

An Oxygen Back-up Cylinder is must while
using the Oxygen Concentrator. The Foundation
shall not be responsible for any interruption in
oxygen therapy due to power failure or
equipment malfunction.



POWER BACKUP INVERTER IS STRONGLY RECOMMENDED

A Power Back-up (Inverter/UPS or Generator)
is strongly recommended to ensure
uninterrupted operation of the Oxygen
Concentrator during power outages.



TERMS & CONDITIONS



Equipment must be
collected from and
returned to the
Trust Office.



The applicant shall be
responsible for any
loss, damage, theft,
or misuse of the
equipment during
the period of use.



Applicants must
arrange the required
Oxygen Mask /
Bi-PAP Mask, tubing,
and other patient
consumables as
prescribed by the
treating doctor.



The Foundation
reserves the right
to recall the
equipment
whenever
required.



The decision of the
Trustees shall be
final and binding in
all matters relating to
assistance and
equipment allocation.



Medical equipment is provided on a humanitarian basis and is subject to availability.
Submission of an application does not guarantee approval or allotment.

FOR OFFICE USE ONLY

Application No.: _____ Date: _____
Received By: _____



PATIENT
PASSPORT SIZE
PHOTO

Page 1 of 2 – Applicant & Medical Details

Administrative Office
H.No. 3-7/21, Shiva Sai Ram Colony,
Road No.4, Near SBH Colony Arch,
Munganoor, Hyderabad – 501511,
Telangana.

96664 66677

helpline.yf@gmail.com

www.yarramadafoundation.org

Trust Registration No.
IV/85/2025



PranaVayu
Scan to visit our Website

Beneficiary Code: Application No.: Date: ____/____/____

1 APPLICANT DETAILS

Applicant Name: _____
Relationship with Patient:
☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Son ☐ Daughter
☐ Brother ☐ Sister ☐ Relative ☐ Caregiver ☐ NGO ☐ Other _____
Date of Birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other _____
Occupation: _____ Annual Family Income: ₹ _____
White Ration Card No.: _____ Aadhaar No. (Last 4 Digits): _____

2 PATIENT DETAILS

Patient Name: _____
Date of Birth: ____/____/____ Age: _____ Gender: ☐ Male ☐ Female ☐ Other _____
Mobile No.: _____ Alternate Mobile No.: _____
Email ID: _____
Aadhaar No. (Last 4 Digits): _____ ABHA ID (Optional): _____
White Ration Card / BPL Card No.: _____
Address: _____
District: _____ State: _____ PIN Code: _____

3 MEDICAL DETAILS

Diagnosis / Disease: _____
Treating Hospital: _____
Doctor's Name (Treating): _____ Doctor Mobile: _____
Referral Doctor Name: _____ Referral Hospital Name: _____
Treatment Status: ☐ Admitted ☐ Discharged ☐ Home Care ☐ Ongoing Treatment
Referred By: ☐ Hospital ☐ Doctor ☐ Government Health Centre ☐ NGO ☐ Self ☐ Other _____
Medical Insurance Available: ☐ Yes ☐ No Insurance Details: _____
Ayushman Bharat / Aarogyasri Beneficiary: ☐ Yes ☐ No If Yes, Card No.: _____

4 MEDICAL EQUIPMENT REQUESTED

☐ Oxygen Concentrator (5 LPM) ☐ Oxygen Concentrator (10 LPM) ☐ Bi-PAP Machine ☐ Other (Please Specify) _____
Expected Duration of Use: _____

5 EMERGENCY CONTACT

Contact Person Name: _____ Relationship: _____
Mobile No.: _____ Alternate No.: _____
Address: _____



6 DOCUMENT CHECKLIST (Please ✓)

- ☐ Aadhaar Card / PAN Card / Voter ID
- ☐ Address Proof
- ☐ White Ration Card (BPL) / BPL Card
- ☐ Doctor Prescription / Advice Letter
- ☐ Hospital Discharge Summary
- ☐ Doctor Certificate
- ☐ Income Proof (if available)
- ☐ Passport Size Photograph
(Please attach 1 passport size
photograph of the patient)
- ☐ Medical Reports / Test Reports
- ☐ Any Other Document _____

7 FINANCIAL ASSISTANCE RECEIVED FROM OTHER TRUSTS

Sl. No.	Trust / Organization Name	City	Type of Assistance	Amount (₹)	Status (Applied / Approved / Received)
1					
2					
3					
4					
5					

8 SAFETY & EQUIPMENT REQUIREMENTS



OXYGEN CYLINDER BACKUP (MANDATORY)

- ☐ Available
- ☐ Not Available

If Available, Cylinder Capacity: _____ (Ltrs)



POWER BACKUP AVAILABLE (STRONGLY RECOMMENDED)

- ☐ Yes
- ☐ No

Type of Power Backup (✓):

- ☐ Inverter
- ☐ UPS
- ☐ Generator
- ☐ Other _____

Capacity / Rating: _____ (VA / Watts)

9 DECLARATION

I hereby declare that the information provided above is true and correct to the best of my knowledge. I understand that submission of this application does not guarantee approval. I agree to comply with all the rules and conditions of Yarramada Foundation regarding the use and return of the medical equipment. I also understand that any false information may lead to rejection of this application and legal action.

Place: _____

Date: _____ / _____ / _____

Applicant Signature

Patient / Guardian Signature
(If applicable)

FOR OFFICE USE ONLY

Application Verified By:		Date:	
Documents Verified:	☐ Yes ☐ No	Verified By (Sign):	
Approved / Rejected:	☐ Approved ☐ Rejected	Approved By (Sign):	
Remarks:			

EQUIPMENT ISSUE DETAILS

Equipment Issued:	☐ Oxygen Concentrator (5 LPM)	☐ Oxygen Concentrator (10 LPM)	☐ Bi-PAP Machine	☐ Other _____
Equipment ID / Serial No.:				
Date of Issue:	_____ / _____ / _____	Expected Return Date:	_____ / _____ / _____	
Security Deposit (Refundable): ₹	_____	Receipt No.:	_____	
Equipment Condition at Issue:	☐ Excellent	☐ Good	☐ Fair	
Issued By (Sign):	Applicant Signature at Delivery:			

NOTE: • Equipment is provided **FREE OF COST** (subject to availability).
• A refundable security deposit may be applicable as per Foundation policy.





PATIENT REFERRAL & MEDICAL EQUIPMENT SUPPORT RECOMMENDATION

To

The Chairman / Authorized Representative

Yarramada Foundation

A Public Charitable Trust

A Pranavayu Initiative – Reviving Hope of Life

**Subject: Recommendation for Medical Equipment Support – Oxygen Concentrator / BiPAP /
Other Medical Equipment**

Dear Sir/Madam,

This is to certify that Mr./Mrs./Ms. _____ Age/Gender: _____
has been examined/treated at _____ Hospital / Clinic

Based on the patient's present medical condition, the patient requires

☐ 1. Oxygen Concentrator ☐ 2. BiPAP Machine ☐ 3. Other Equipment _____

for medical/respiratory support.

- Diagnosis / Medical Condition: _____ Oxygen Requirement: _____ LPM
- Duration of Medical Equipment Requirement: _____ Days

The patient/family has expressed difficulty in arranging the required medical equipment due to financial circumstances.

We therefore recommend this patient to **Yarramada Foundation** under its **"A Pranavayu Initiative"** for consideration of charitable assistance, subject to the Foundation's eligibility criteria, availability of equipment and verification process.

This recommendation is being issued based on the patient's medical requirement and does not constitute any guarantee regarding approval or provision of equipment by the Foundation.

We request you to kindly consider the case on humanitarian grounds.

For

Signature: _____

Name of Doctor: _____

Designation: _____

Medical Registration No.: _____

Hospital Name: _____

Hospital Address: _____

Hospital Seal & Stamp

Date: _____

Place: _____



Compassion | Dignity | Transparency | Responsible Use

Every Breath Matters