

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

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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: \_\_\_\_\_

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

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

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**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**

