GOA LABOUR WELFARE BOARD

SCHEME No. X

SCHEME FOR TREATMENT OF MENTALLY CHALLENGED AND SPASTIC CHILDREN OF INDUSTRIAL WORKERS.

OBJECT: The scheme contemplates to provide medical / monetary relief to the children of the Industrial Workers covered under the Goa, Daman and Diu Labour Welfare Act, 1986. The Assistance shall be to look after the child who is mentally challenged and suffering from spasticity fully dependent upon the parents / guardians for all day to day activities for which a normal child of that age does not need such assistance.

1. **Eligibility:** A worker who has put in at least six months of continuous service irrespective of any pay limit shall be entitled to the benefits.
   The child should be certified as mentally challenged to the extent that it necessitates the parental assistance by the Institute of Psychiatry in case of mentally challenged and in case of the child suffering from spasticity it should certified by the Orthopaedic Surgeon / Physician of Asilo Hospital, Mapusa / Goa Medical College, Panaji or Hospicio, Margao. Such certificate should be submitted once in a year till the infirmity lasts or till the financial assistance is claimed.

2. **SUBSISTENCE ALLOWANCE:** Where the worker (a) happens to be the only earning member of the family and (b) has no other source of income during the period of treatment of his child shall be paid subsistence allowance @ Rs. 3000/- p.m.

3. **SUBMISSION OF CLAIM:** For re-imbursement of expenditure for treatment, an application in the prescribed Form '**A**' (enclosed) should be submitted by the workers to the Secretary though his employer duly certified by the competent Medical authorities of the Hospital as stated above

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SCHEME – X

FORM 'A'

APPLICATION FOR CLAIMING RE-IMBURSEMENT OF EXPENDITURE OF THE TREATMENT OF MENTALLY CHALLENGED CHILD/CHILD SUFFERING FROM SPASTICITY

To,
The Secretary,
Goa Labour Welfare Board.

Sir,

I herby apply for Subsistence Allowance for treatment of my Son/Daughter who is undergoing treatment for_____ (mention the name of the hospital where the treatment has been taken.)

1. Name of the applicant in full (in block letters) :
2. Full address of the applicant :
3. Name of the patient :
4. Date of birth and age of the child/dependent (supported by birth certificate) :
5. Age and relationship with the worker/ applicant :
6. Name and address of the Industrial Establishment in which the Applicant/Workmen is employed. :
7. Date of continues employment in the Industrial Establishment showing the total period of continuous service :
8. Is the applicant's wife or husband employed? Give details :
9. Full address of the Hospital where the department is undergoing the treatment :
10. Amount claimed as Subsistence Allowance showing the duration of the claim :

I hereby declare that the particulars furnished above are correct to the best of my knowledge and belief. If any of the particulars is found to be in-correct, I realize that I will be liable for suitable action apart from refund of financial assistance received by me.

Signature of the applicant
Or Thumb impression
(Name in block letters)

Place:

Date:

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ATTESTATION BY THE MANAGER/OWNER OF THE INDUSTRIAL ESTABLISHMENT.

Certified that Shri./Smt. _____ is employed in this Industrial Establishment as _____ continuously w.e.f _____ and information furnished by him/her above is correct to the best of my knowledge and belief.

Place:

Date:

Signature: _____

Designation with seal:
Of the Management/Industrial Establishment.

CERTIFICATE OF THE MEDICAL OFFICER OF THE RECOGNISED MENTAL HOSPITAL

Certified that _____Son/Daughter of Shri/Smt. _____ who is employed as _____in the establishment of _____ has been examined in this Hospital and has been diagnosed as a case of Mental Retardation/Spasticity and does/does not need active treatment.

Signature

Name and Designation:

Seal of Medical Superintendent of the Institute of Psychiatry and Human Behaviour, Bambolim in case of Mentally Retarded child and of Orthopaedic Surgeon/Physician of Asilo Hospital, Mapusa, Hospicio, Margao and Goa Medical College in case of Spasticity.

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ALIVE CERTIFICATE
***(To be submitted yearly)**

PART – (A)

DETAILS OF THE BENEFICIARY UNDER GOA LABOUR WELFARE BOARD SCHEME

Full Name Of The Beneficiary: Shri/Smt./Kum._____ Full Address:_____ Contact No ._____

Signature /L.H.T of The Beneficiary
(To Be Signed In The Presence Of Govt .Gazetted Officer)

PART – (B)

(FOR USE OF GOVT. GAZETTED OFFICER ONLY)
CERTIFICATE

This is to certify that I have seen Shri/Kum_____ son/daughter of Shri./Smt./Kum. _____ a beneficiary of the scheme for Treatment of Mentally Challenged and Sceptic Children of Industrial Workers, and state that he/she is Alive as on _____.

The Beneficiary has signed the above Part – A of the certificate in my presence on the _____ day of _____ (month)_____(year).

Signature of Govt .Gazetted Officer with date
(Name, Designation, & Stamp of Govt .Gazetted Officer)