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

Form 1-B

APPLICATION FORM FOR CLAIM OF SECOND INSTALLMENT UNDER PMMVY

1010	indicity fields	
1.	I, Smt (Registration name of	beneficiary)*had registered under the PMMVY
	scheme with Anganwadi Centre / Approved Health Facility /V	illage
2.	Aadhaar/Identity number of beneficiary*:	(enclose copy of proof)
	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 Undertaking; j) Any other Photo Identity Card issued by State Governme k) Certificate of identity with photograph issued by a Gazet I) Health Card issued by Primary Health Centre (PHC) or Go m) Any other document specified by the State Government	nt or Union Territory Administrations; ted Officer on official letterhead; vernment Hospital;
3.	Date of registration under PMMVY at Anganwadi Centre /	/illage*:/
4.	ANC Date*:/	
5.	Tick yes, if already registered under the scheme*: Yes (If no, then fill Form 1-A) (If yes, enclose copy of acknowled	
6.	Date of claiming the second instalment under PMMVY scho (Enclose a copy of MCP Card, and Aadhaar/Identity Card)*	eme* :/
7.	Health ID of beneficiary:	
Sign	ature/Thumb Impression Date	Place

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*: 9. Checklist of documents enclosed: S.No Document to be enclosed **Document Enclosed** Yes-Y 1 Aadhaar/Identity Card of beneficiary (Identity Card should be same as the one used for registration under the scheme) 2 MCP Card with ANC Details 3 Acknowledgement Slip Date of claiming second instalment under PMMVY scheme at Anganwadi Centre /Village (dd/mm/yy)*: Date of submission to Supervisor / ANM*: -----/-----/-----Signature Date Place Verification by Supervisor / ANM* _ (Name of Supervisor / ANM)* have verified the information captured in this form and that the form is duly complete. Signature Date Sector Code

8. Details to be filled by Anganwadi Worker / ASHA /ANM

	District: State/UT*:	duly filled <u>Form 1-B</u> along with documents as per checklis
Cmt *	District: State/UT*:	
	District:	
	5	
	Project/fiealth block Name.	
	Project/health Block Name:	
	Sector Name:	
	Post Office Name:	
	Anganwadi Worker / ASHA /ANM Name*:	
	Village Code*:	
	Anganwadi Centre Code*:	
	Village/Town Name*:	,
Ackno	Village/Town Name*: Anganwadi Centre Code*: Village Code*:	ary* (by Anganwadi Worker / ASHA /ANM)