

APPLICATION FORM FOR ASSISTANCE
 अप्लिकेशन फॉरम

(Healthcare)
 (स्वास्थ्य सहायता)

Koshika
 Foundation
 Building Block of Life

APPLICATION NO.
 अप्लिकेशन नंबर

E/0525/0041

APPLICATION DATE
 अप्लिकेशन तिथि

1/5/25

NAME OF APPLICANT
 अप्लिकेशन के द्वारा दिया गया नाम

ANANYA KUMARI

AGE IN YEARS
 वय (वर्षों में)
 04 YEARS FEMALE

FATHER'S/HUSBAND'S NAME
 पति/पत्रिका के नाम

SUDHANSU (FATHER)

PRESIDENT RESIDENCE ADDRESS
 वासस्थान का पृष्ठीय वासस्थान का विवर

KEHATPUR, WARD 91, SAMASTIPUR, BIHAR -
 843522

PERMANENT RESIDENCE ADDRESS
 वासस्थान का अस्तित्व स्थान

OCCUPATION
 विवर

FARMER (FATHER)

MARRIED (Yes) / UNMARRIED (Father)

TOTAL ANNUAL INCOME
 कुल वार्षिक आय

1,08,000 (FATHER)

(Attach Proof of Income)
 (आय का संपर्क स्रोत)

PAN No. एपीएन नंबर

ARE YOU AN INCOME TAX ASSESSEE? (Tick whichever is applicable)

प्रौद्योगिकी विभाग के द्वारा विचार किया जाना चाहिए।

Yes / No
 हाँ / नहीं

FAMILY DETAILS घरेलू विवर

Sl. No. संख्या	Name of Family Member जीवन के सदस्य का नाम	Age (Years) वय (वर्षों में)	Gender लिंग	Relation with Applicant अप्लिकेशन के साथ की सम्बन्ध
1	SUDHANSU	23	MALE	FATHER
2	ANANYA KUMARI	04	FEMALE	MOTHER
3	BRAHMDEV KUMAR	52	MALE	GRANDFATHER

BANKS FOR REQUESTING ASSISTANCE (Tick whichever is applicable)
 बैंकों के द्वारा दिया जाना चाहिए।

SPG, Cans (Bank Book Copy)	EPW Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basic Proof उपलब्ध कराएं
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PURPOSE FOR REQUESTING ASSISTANCE
 दिया जाना चाहिए वास्तविक कारण

Sl. No. संख्या	Medical Reports/Prescriptions Attached जोड़ा जाना चाहिए और इसके साथ लिखा जाना चाहिए।		
1.	DIAGNOSIS - RETINOBlastoma		
2.	TREATMENT - EVA		

ASSISTANCE BEING AWARDED FOR SAME PURPOSE FROM OTHER SOURCES
 द्वारा दिया जाना चाहिए जो साथी वास्तविक कारण के लिए दिया जाता है।

No

Sl. No. संख्या	NAME OF OTHER SOURCE जीवन के सदस्य का नाम	AMOUNT OF ASSISTANCE BEING AWARDED दिया जाना चाहिए रुपये

DECLARATION by APPLICANT

- 11) I hereby confirm that all details in this Form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance liable for rejection/cancellation.

23) I solemnly confirm that assistance, if received from Koshika Foundation, will be used only for the 'purpose' as stated in this Form, for which such assistance was requested by me.

31) I hereby confirm that I have not & will not in future, avail of reimbursement, in cash or in kind, from any other source (employer/insurance company) of the amount for which this assistance is requested.

1) मैं अपना स्वामी के दस्तावेज़ के लिए यह नियमों को अवश्य बदल देता हूँ कि यह सभी नियम इस दस्तावेज़ के लिए उपयोग की जरूरत है।

2) यह दस्तावेज़ पारा "कोशिका फाउण्डेशन", न ही या भी है, या उसके लिए और वो भी न होने वाला नाम, या दो जगह में लिखा गया है।

3) मैं अपने दस्तावेज़ की जांच की जाए तो यह दस्तावेज़ आधिकारिक रूप से बदल दिया जाएगा।

AGREEMENT by APPLICANT

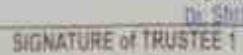
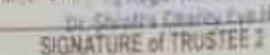
APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

માનુષની

AGREEMENT by HOSPITAL

By affixing her/his/her signature our Authorised Signatory for recommending this application for financial assistance from Koraika Foundation, we (Head/Chair) hereby affirm & accept following:

RECOMMENDED FOR ACCEPTANCE

Date of Surgery विकार की तिथि 5/5/15	 Dr. CHHAVI GUPTA (Name of Dr. & Regn. No. with Stamp) Dr. Chhavi Gupta, M.B.B.S., D.A.B.O., D.A.M.S. FOR INTERNAL USE of KOSHISHA FOUNDATION Dr. Shanti's Charity	(Name, Designation & Name of Authorized Signatory on behalf of Hospital) Dr. Chhavi Gupta, M.B.B.S., D.A.B.O., D.A.M.S. KOSHISHA FOUNDATION Dr. Shanti's Charity, Mumbai
SIGNATURE OF TRUSTEE 1 न्यायीक संकाय 1 		SIGNATURE OF TRUSTEE 2 न्यायीक संकाय 2 



Dear Mr. Tandon



Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby, Ananya Kumarji- E/0525/0041

Estimate cost of treatment
Dr. Shroff's Charity Eye Hospital
Retinoblastoma Surgeries

Name	Baby, Ananya Kumarji	Address/ Phone:	Ward 91, Rehapur, Samastipur, Bihar-848522		
MR N	DEL-G-21-02-3960	Age/Sex	4 years	Female	
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	05/05/2025	Examination under Anesthesia	2000	1	2000
		Total			2000

Best Regards,

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL

5027, Kedar Nath Road Daryaganj, New Delhi-110002 India

Ph:- 011-4352 4444, 4352 8888, Fax : 011-43528818

E-mail : sceh@sceh.net, Website : www.sceh.net

OTHER CENTRES

ALWAR • SAHARANPUR • MEERUT • LAKHIMPUR KHERI • VRINDAVAN • KAROL BAGH (DELHI)