

MOM-4-25-05-0276

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य सहायता)



Koshika
FOUNDATION
Building lives of life

APPLICATION No.

आवेदन संख्या

E/0525/0060

APPLICATION DATE

आवेदन तिथि

10/5/25

NAME of APPLICANT

आवेदक का नाम

KUSHAURA

AGE-YEARS

वर्ष-वर्ष

SEX

लिंग

52 YEARS

MALE

FATHER/SPOUSE'S NAME

पिता/पत्नी का नाम

SOBHIT (FATHER)

PRESENT RESIDENCE ADDRESS

वर्तमान निवास पता

KULVANI MADANPUR, FARIDKA, KHERI, U.P.
252804

PERMANENT RESIDENCE ADDRESS

स्थायी निवास पता

OCCUPATION

व्यवसाय

FARMER (FATHER)

MARRIED (वैवाहिक) / UNMARRIED (अवैवाहिक)

TOTAL ANNUAL INCOME

कुल वार्षिक आय

96,000 (FATHER)

(Attach Proof of Income)

(आय का सबूत जोड़ें)

PAN No.

पैन संख्या

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

क्या आप आय-कर दाता हैं? (जो मान्य हो उस पर 'हाँ' या 'नहीं' का चिह्न लगाएं)

Yes / No

हाँ / नहीं

FAMILY DETAILS (परिवार विवरण)

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक से संबंध
1.	SOBHIT	18	MALE	FATHER
2.	RIKI DEVI	18	FEMALE	MOTHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिए किसे चिह्नित करें

SPL Card (Attach Card Copy) संयोजी रेशन कार्ड का प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि जोड़ें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग का प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि जोड़ें)	Ration Card (Attach Copy) रेशन कार्ड का प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि जोड़ें)	Any Other (Attach Proof) अन्य कोई प्रमाण
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"PURPOSE" for REQUESTING ASSISTANCE

सहायता हेतु, किये गये निम्नलिखित कारण:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अनुसंधान/दवाखाने से जारी की गई डॉक्टरों द्वारा संलग्न
1.	DIAGNOSIS - RETINOBLASTOMA
2.	TREATMENT - FUA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के लिए कोई अन्य सहायता किसी अन्य स्रोत से ली जा रही है?

NO

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED तो गई सहायता का राशि
	NA	

DECLARATION by APPLICANT: कर्तव्य द्वा. पंजीय. पत्र:

- 1) 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 null and void for rejection/cancellation.
- 2) I solemnly confirm that assistance, if received from Kashi Foundation, will be used only for the "purpose", as stated in this Form, for which such assistance was requested by me.
- 3) I hereby confirm that I have not & will not in future, avail of reimbursement, in part or in full, from any other source/employer/insurance company, of the amount for which this assistance is requested.
- 1) मैं यहाँ पर घोषणा करता हूँ कि इस प्रश्न में दिए गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण एवं कारण असत्य पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- 2) मैं दृढ़ता से घोषणा करता हूँ कि "कारण" अनुसार, से लेने का हो, इसका उपयोग उम्मीद के अनुसार ही मुझे मिले बिना उपयोग, जो इस प्रकार में प्राप्त होगा।
- 3) मैं यहाँ पर घोषणा करता हूँ कि बिना सहायता देने पर वापस को नहीं है, इस धन का वापस या सहायता किसी अन्य स्रोत/रोजगार/बीमा कम्पनी से न हो, सिवाय कि और न ही वापस में लेंगे।

AGREEMENT by APPLICANT (आवेदक द्वारा कर्म)

- AGREEMENT by APPLICANT** (अवरोधक द्वारा कर्म)
- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to use/publish/post-up/reproduce my name, address, photo & details of the "purpose", for which such assistance is requested/granted, through any medium - including but not limited to verbal, print, electronic, for soliciting donations for Koshika Foundation and/or disseminating information about it's activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfilment of the "purpose" for which assistance is being requested.
- 2) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/granted, will not automatically entitle me for receiving or continuing the said assistance. The decision for granting and/or continuing the assistance will rest solely with the Trustees of Koshika Foundation, and their decision in this regard will be final and acceptable to me.
- 1.) इस प्रश्न पर उत्तर देनेवाले को अपने नाम, पता, फोटो और कोई विवरण इस प्रश्न में घोषित है, उसे "कोशिका" समूह यात्री, घर, परिवार/घर दूसरे उद्देश्य से मुझे सहायता के लिए किसी भी प्रकार साधन से प्रभावित करने के लिए अधिकृत है। मैं प्रश्न का विचार से इच्छा को अपने हाथ में करने के लिए "कोशिका फाउंडेशन" व उसकी अधिकृत हैं।
- 2.) मैं (आवेदक) इस बात से सहमत हूँ कि वेत-सम, घर, फोटो और विवरण को कि साक्षात् मे उद्देश्यों से प्रेषित है मुझे लाभ, सहायता का संकेत नहीं करता। इस सम्बंध में "कोशिका" समूह उसकी अधिकृत को निर्धारित जीवन और लक्ष्यकारी होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

अध्यक्ष: जी, हमें क्या था। समुद्र का विभाजन।

साहित

AGREEMENT by HOSPITAL (HSEB 100 000)

By affixing hereunder, signature of our Authorized Signatory for recommending this case/patient for financial assistance from Keshika Foundation, we (Hospital) hereby affirm & accept following:

- 1) That we neither are presently nor will in future avail of financial assistance from another NGO or any other source, for the same patient/case, as we are requesting to get from Koshika Foundation, to the extent that such assistance is granted by Koshika Foundation. If the requested assistance is not granted by Koshika Foundation, in part or in full, then the Hospital reserves its right to make up the shortfall from another NGO or any other source. This confirmation essentially states that the Hospital will not avail any duplicate assistance for the same patient/case from any other NGO or any other source.
- 2) The assistance from Koshika Foundation is only financial in nature. The choice of the treatment/procedure advised/conducted by the Hospital on the patient, is based on the arrangement between the patient & the Hospital, and is in no way influenced by Koshika Foundation. Hence, the Hospital will assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

हामी अधिकांश प्रस्तावहरूको लागि सेवामार्गहरूको "अतिरिक्त समन्वयन" नै विशेषतामाथि अनुमतिपत्रको साथै छ, जसले हाम्रो (इन्टरनेट) विवरणहरूमाथि अनुमतिपत्रको साथै छ।

- [illegible]

RECOMMENDED FOR ACCEPTENCE

सर्वाङ्गता के लिए संस्कृति

Date of Surgery
ऑपरेशन की तारीख

1950s

Dr. CHHAVI GUPTA
(Name of Dr. in Regd. No. with Stamp)
Jointed and Jointed, Jointed and Jointed Services

(Name, Designation & Stamp of Authorized Signatory)
on behalf of Hospital
Director, Medical College Hospital, Patna

FOR INTERNAL USE OF KOSHIKA FOUNDATION

আপনার চমকপ্রদ গল্পগুলি শুধুমাত্র একটি ক্লিকের দূরত্বেই!

SIGNATURE of TRUSTEE 1

ज्यामी हस्ताक्षर ।

Exchanged

SIGNATURE of TRUSTEE 2

2011年 6月 24日

2020



Dr. Shroff's Charity Eye Hospital

Caring for the community since 1914...



Dr. Shroff's Charity Eye Hospital
Delhi is NABH Accredited

31st May 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Mast. Kushagra- E/0525/0060

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital <u>Retinoblastoma Surgeries</u>					
Name		Mast. Kushagra	Address/ Phone:	Kuiyan, Madarpur, Farendia, Kheri, Uttar Pradesh-202804	
MR N		MOM-G-25-06-0276	Age/Sex	2 years	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	13/05/2025	Examination under anesthesia	2000	1	2000
2	15/05/2025	MRI	6500	1	6500
		Total			8500

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 : 011-43528816

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

OTHER CENTRES

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