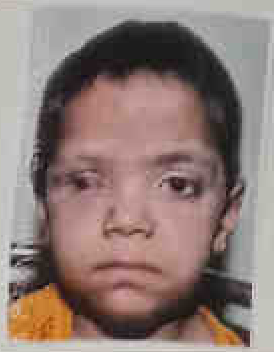
DEL-P-24-07-0520

APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika foundation

Building Wall of life



APPLICATION No. / [illegible]	E / 0625 / 0088	APPLICATION DATE / आवेदन तिथि	12/6/25
NAME of APPLICANT / आवेदक का नाम	ARCHIT	AGE-YEARS / आयु वर्ष: 05 YEARS	SEX / लिंग: MALE
FATHER'S/SPOUSE'S NAME / [illegible]	SAURAV (FATHER)		

PRESENT RESIDENCE ADDRESS / वर्तमान आवासीय पता

GRAM NAGARA ALANPUR, MOHAMMADABAD, FARRUKHABAD, U.P. - 209651.

PERMANENT RESIDENCE ADDRESS / स्थाई आवासीय पता

OCCUPATION / [illegible]	FARMER (FATHER)	MARRIED (विवाहित) / ~~UNMARRIED (अविवाहित)~~
TOTAL ANNUAL INCOME / कुल वार्षिक आय	60,000 (FATHER)	(Attach Proof of Income) / (आय का सबूत संलग्न)
PAN No. / [illegible]		
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable) / [illegible]		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 के साथ संबंध
1.	SAURABH	27	MALE	FATHER
2.	[illegible]	25	FEMALE	MOTHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) / [illegible]

BPL Card (Attach Card Copy) / [illegible]	EWS Certificate (Attach Certificate Copy) / [illegible]	Ration Card (Attach Copy) / [illegible]	~~Any Other~~ Basis/Proof / अन्य कोई साक्ष्य

"PURPOSE" for REQUESTING ASSISTANCE: / [illegible]

Sr. No. / क्रम संख्या	Medical Reports/Prescriptions Attached / [illegible]
1.	DIAGNOSIS - RETINOBLASTOMA
2.	TREATMENT - EUA, CHEMO.

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES / [illegible] NA

Sr. No. / क्रम संख्या	NAME of OTHER SOURCE / अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED / [illegible]
	NA	

DECLARATION by APPLICANT [illegible]

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, if any, liable for [illegible].

2) I [illegible] 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.

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.

[illegible]

AGREEMENT by APPLICANT [illegible]

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to [illegible] my name, address, photo & details of the "purpose" for which such assistance is requested/granted, through any [illegible], 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 [illegible] 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.

[illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

[illegible]

गजा

AGREEMENT by HOSPITAL (अस्पताल द्वारा करार)

By affixing [illegible] signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika 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 it's right to make up the shortfall from another NGO or any other source. This confirmation [illegible] 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 & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

[illegible]

RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख		
16/6/25	Dr. CHHAVI GUPTA (Name of Dr. & Regn. No. with Stamp) [illegible] Regd. No. 106745	Dr. SIMA DAS Director (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्ताक्षर [illegible] अधिकारी Eye Hospital

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 ट्रस्टी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 ट्रस्टी हस्ताक्षर 2
[signature]	[signature]

30-11-2024

Dr. Shroff's Charity Eye Hospital
Caring for the community since 1922...

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

30th June 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Mast. Archit- E/0625/0088

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

Name		Mast. Archit	**Address/ Phone:**	Gram Nabada Atanpur, Mohamdabad, Farrukhabad, U.P- 206451	
MR N		DEL-P-24-07-0520	**Age/Sex**	5 years	Male
S. No.	**Treatment date**	**Items**	**Cost per Unit**	**No. of unit**	**Aprox. Cost**
1	2025-06-16	Examination under Anesthesia	2000	1	2000
2	2025-06-16	Chemotherapy	2500	1	2500
		Total			**4500**

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