VRN-C-20-02-0015

APPLICATION FORM FOR ASSISTANCE (Healthcare)
सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika Foundation

APPLICATION No. : आवेदन संख्या :	V/1120/0152	APPLICATION DATE : आवेदन तिथी	18/11/20
NAME of APPLICANT : आवेदक का नाम	Shukhram	AGE-YEARS आयु-वर्ष: 64	SEX लिंग: M



PASTE PHOTO HERE

Preop Postop
(0152) Shukhram

FATHER'S/SPOUSE'S NAME : पिता/पति का नाम: Ram Singh

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता:
Rampur, Aligarh,
Distt. Aligarh, U.P. 202127

PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता:
Same as above

OCCUPATION व्यवसाय: Farmer.

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME : कुल वार्षिक आय: 21000/-

(Attach Proof of income) (आय का साक्ष्य संलग्न) NA

PAN No स्थाई खाता संख्या:

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता है (जो लागू हो उस पर सही का निशान लगायें) Yes / No हां / 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 सम्बंध
1	Shanti	63	F	Wife
2-	Sunita	25	M	Daughter
3	Rahul	21	M	Son
4	Vinod	17	M	Son

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिये विनति आधार:

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अन्य आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (राशन कार्ड की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य

"PURPOSE" for REQUESTING ASSISTANCE
सहायता हेतु किये गये विनती का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
	RE - Senile Cataract
	LE - P.P.
	Surgery - (RE) SICS + IOL

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया हो?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशी
1	DSCS	20000/-

DECLARATION by APPLICANT: आवेदक द्वारा घोषणा 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 liable for rejection/cancellation.
2) 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.
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) [illegible]
2) [illegible]
3) [illegible]

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its Trustees to use/publish/put-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 its activities/achievements. Such use of my photo & data is 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) [illegible]
2) [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:
आवेदक के हस्ताक्षर या अंगूठे का निशान

सुरवराम

AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

By affixing hereunder 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 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.

[illegible]
1) [illegible]
2) [illegible]

RECOMMENDED FOR ACCEPTENCE स्वीकृति के लिए संस्तुति		
Date of Surgery ऑपरेशन की तारीख 19/11/20	Dr. Ashwini Kumar M.B.B.S., M.S. Ophthalmology Reg. No. - 65028 Time........ Date........ (Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. न.	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION आंतरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2

30.12.2019