DEL 4-23-12-8424

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

Koshika foundation

APPLICATION No.: आवेदन संख्या : E/0924/0176	APPLICATION DATE: आवेदन तिथि 10/9/24		
NAME of APPLICANT: आवेदक का नाम MAST RUDRA ANIKET	AGE-YEARS आयु-वर्ष 14 YEAR	SEX लिंग MALE	PASTE PHOTO HERE
FATHER'S/SPOUSE'S NAME: पिता/पति का नाम JAY SINGH (FATHER)			
PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता VILLAGE KALLANPUR, DISTRICT - FATEHPUR, UTTAR PRADESH - 212601			
PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता			
OCCUPATION: व्यवसाय LABOURER (FATHER)		MARRIED (विवाहित) / UNMARRIED (अविवाहित/ब्र.)	
TOTAL ANNUAL INCOME कुल वार्षिक आय 96,000 (FATHER)		(Attach Proof of Income) (आय का संलग्न करें)	
PAN No. पैन कार्ड संख्या			
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आयकर कर दाता हैं (जो सत्य हो उस पर सही का निशान लगायें)		Yes / हाँ	No / 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	JAY SINGH	39	MALE	FATHER
2	SHEELA DEVI	35	FEMALE	MOTHER

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) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (प्रमाण पत्र 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 आवश्यक डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
1	DIAGNOSIS - RETINOBLASTOMA
2	TREATMENT - ENUCLEATION

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES NO
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्त्रोत से लिया गया है?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
	NIL	

NGI - U - 23 - 07 - 6924

DECLARATION by APPLICANT: [illegible]

1) I hereby confirm that all details in the Form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, 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 the 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 use/publish/print/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 & 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.

[illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

[illegible]

[illegible] (Mother)

AGREEMENT by HOSPITAL [illegible]

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 it's 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 & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

[illegible]

RECOMMENDED FOR ACCEPTENCE

[illegible]

Date of Surgery [illegible]	(Name, Designation & Signature of Doctor) [illegible]	(Name, Designation & Signature of Authorised Signatory) [illegible]
12/9/24	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services Regd. No. 100745 Dr. Shroff's Charity Eye Hospital	Dr. SIMA DAS Director Oculoplasty and Ocular oncology services Director, Medical Education Department Regd. No. 6893 Dr. Shroff's Charity Eye Hospital

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

SIGNATURE of TRUSTEE 1 [illegible]	SIGNATURE of TRUSTEE 2 [illegible]
[signature]	[signature]

11-04-2024

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

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

30th September 2024

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Mast. Rudra Aniket Singh- E/0924/0176

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

Name		Mast. Rudra Aniket Singh	Address/ Phone:	Village Kallanpur, District-Fatehpur,Uttar Pradesh-212601	
MR N		DEL-G-23-12-8424	Age/Sex	1 year	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	12/09/2024	Examination under anesthesia (EUA)	2000	1	2000
		Total			**2000**

Best Regards

Dr. Sima Das P

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL
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