

DEL-P-21-09-3637

APPLICATION FORM FOR ASSISTANCE

(Healthcare)
(स्वास्थ्य सहायता)



APPLICATION No.: **E/0924/0182** APPLICATION DATE: **8/9/24**

NAME of APPLICANT: **BABY VERONICA** AGE-YEARS: **3** SEX: **FEMALE**

FATHER'S/SPOUSE'S NAME: **PRAASHANT (FATHER)**

PRESENT RESIDENCE ADDRESS: **NO. 55, POCKET-6, ROHINI, GURGAON, DELHI-110085**

PERMANENT RESIDENCE ADDRESS: **same as above**



OCCUPATION: **PRIVATE JOB (FATHER)** MARRIED (विवर्धित) / UNMARRIED (अविवर्धित): **NA**

TOTAL ANNUAL INCOME: **1,80,000 (FATHER)** (Attach Proof of Income)

PAN No. **XXXXXX** ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): **Yes / No**

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	PRAASHANT	33	MALE	FATHER
2	RACHINA	30	FEMALE	MOTHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

BPL Card (Attach Card Copy) गरीबी रखा के नीचे प्रमाण पत्र (प्रमाण पत्र को साथ में संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र को साथ में संलग्न करें)	Ration Card (Attach Copy) उपभोक्ता कार्ड (प्रमाण पत्र को साथ में संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किसे क्या बिजनेस का उद्देश्य:

Medical Reports/Prescriptions Attached
अस्पताल/डॉक्टर से जारी की गई दवाइयों के नमूने संलग्न

DIAGNOSIS - RETINOBLASTOMA
TREATMENT - EVA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु 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 ले गई सहायता राशि
	NA	

DECLARATION BY APPLICANT

I, the undersigned, hereby declare that I am the owner of the patient's eye and I am not aware of any other person who is claiming ownership of the same. I am not aware of any other person who is claiming ownership of the same. I am not aware of any other person who is claiming ownership of the same.

AGREEMENT by APPLICANT

I, the undersigned, hereby agree & authorize Koshika Foundation and its functionaries to use my name, address, photo & details of the purpose for which such assistance is requested/granted, through any medium, for the purpose of soliciting donations for Koshika Foundation and for disseminating information about its activities. Such use of my photo & details can be made by Koshika Foundation before or after my invitation or attainment of the purpose for which assistance is requested/granted.

I, the undersigned, hereby agree that my such use of my name, address, photo & details of the purpose for which such assistance is requested/granted, through any medium, for the purpose of soliciting donations for Koshika Foundation and for disseminating information about its activities. Such use of my photo & details can be made by Koshika Foundation before or after my invitation or attainment of the purpose for which assistance is requested/granted.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

[Signature]

AGREEMENT by HOSPITAL

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 bear sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

हमारे अतिरिक्त, हमारा यहाँ पर हमारे अधिकृत हस्ताक्षरों के द्वारा हमारा स्वीकार है कि हम (हस्पताल) निम्न प्रकार से राज्य व स्वीकार करते हैं।

1) कि हम न तो वर्तमान और न ही भविष्य में किसी सहायता के लिए किसी अन्य स्रोत से उसी रोगी/रोगी के मामले में मदद मांगेंगे कि हमने "कोशिका फाउन्डेशन" से मदद मांगी है। यदि "कोशिका फाउन्डेशन" द्वारा सहायता विनियमित की जा सकती है तो हमारा स्वीकार है कि हमने "कोशिका फाउन्डेशन" से सहायता मांगी है। हम स्वीकार करते हैं कि हमारे पास कोई भी अन्य सहायता मांगने का अधिकार नहीं है। इस दृष्टि में स्पष्ट कहा जा रहा है कि हमारे पास कोई भी अन्य सहायता मांगने का अधिकार नहीं है।

2. "कोशिका फाउन्डेशन" से जो भी सहायता केवल वित्तीय प्रकृति की है। रोगी का उपचार हमारे द्वारा ही होना चाहिए कि हमें यह उपचार/प्रक्रिया का चुनाव रोगी एवं हमारा स्वीकार है कि "कोशिका फाउन्डेशन" द्वारा किसी प्रकार का कोई दबाव नहीं है। इसलिए हमारे पास रोगी के इलाज सुझाव और अन्य चीजों को जारी रखने का अधिकार है।

RECOMMENDED FOR ACCEPTANCE

Date of Surgery अपरेशन की तारीख 9/9/24	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services Regd. No. 100745 (Name, Designation & Stamp of Authorised Signatory) Dr. Shroff's Charity Eye Hospital	Dr. SIMA DAS Director Oculoplasty and Ocular oncology services Director, Medical Education Department (Name, Designation & Stamp of Authorised Signatory) Dr. Shroff's Charity Eye Hospital
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FOR INTERNAL USE of KOSHIKA FOUNDATION

SIGNATURE of TRUSTEE 1 न्यायी हस्ताक्षर 1 <i>[Signature]</i>	SIGNATURE of TRUSTEE 2 न्यायी हस्ताक्षर 2 <i>[Signature]</i>
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Dr. Shroff's Charity Eye Hospital

Caring for the community since 1922



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

30th September 2024

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby, Veronica Veronica- E/0924/0182

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital <u>Retinoblastoma Surgeries</u>					
Name		Baby, Veronica Veronica	Address/ Phone:	H.no. 55, Pocket 6, Rohini courts, Delhi-110085	
MR N		DEL-P-21-09-3637	Age/Sex	3 years	Female
S. No.	Treatment date:	Items	Cost per Unit	No. of unit	Aprox. Cost
1	09/09/2024	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 : 011-43528816

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

OTHER CENTRES

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