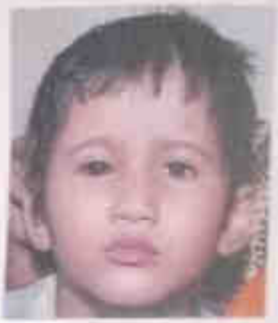
DEL-G-23-02-5671

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

Koshika foundation
Building Block of life



APPLICATION No.: E/0924/0188
APPLICATION DATE: 1/9/24

NAME of APPLICANT: BABY DISHA
AGE-YEARS: 4 YEARS
SEX: FEMALE

FATHER'S/SPOUSE'S NAME: PARVEEN (FATHER)

PRESENT RESIDENCE ADDRESS: KOLYANI, PAURI GARHWAL, UTTARAKHAND, 246235

PERMANENT RESIDENCE ADDRESS:

OCCUPATION: PRIVATE JOB (FATHER)
MARRIED / UNMARRIED: NA
TOTAL ANNUAL INCOME: 1,08,000 (FATHER) (Attach Proof of Income)
PAN No.:
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): Yes / No

FAMILY DETAILS:

Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
1	PARVIN	32	MALE	FATHER
2	SANDHYA	26	FEMALE	MOTHER
3	VIMLA	58	FEMALE	GRANDMOTHER
4	ASHA RAM BHOLE	64	MALE	GRANDFATHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable):

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basis/Proof

"PURPOSE" for REQUESTING ASSISTANCE:

Sr. No.	Medical Reports/Prescriptions Attached
1	DIAGNOSIS - RETINOBLASTOMA
2	TREATMENT - EUA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES: NO

Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED
	NA	

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, 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 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 it's 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 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) [illegible]

2) [illegible]

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

संध्या देवी

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 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]

1) [illegible]

2. [illegible]

RECOMMENDED FOR ACCEPTENCE स्वीकृती के लिए संस्तुति		
Date of Surgery ऑपरेशन की तिथि 2/9/24	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services Regd. No. 100745 Dr Shroff's Charity Eye Hospital (Doctor's Name, Regd. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. न.	Dr. SIMA DAS Director Oculoplasty and Ocular oncology services Director, Medical Education Department Regd. No. [illegible] (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु	
SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2
[signature]	[signature]

15-08-2023

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 Baby. Disha Disha- E/0924/0188

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

Name		Baby. Disha Disha	Address/ Phone:	Kolyani, Pauri garhwal, Uttaakhand-246285	
MR N		DEL-G-23-02-5671	Age/Sex	4 years	Female
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	02/09/2024	Examination under Anesthesia	2000	1	2000
		Total			**2000**

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services