DEL-4-24-02-5893

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

Koshika foundation
Building Block of life

APPLICATION No. आवेदन संख्या	E|124|0241
APPLICATION DATE आवेदन तिथि	15/11/24
NAME of APPLICANT आवेदक का नाम	BABY KHUSHI
AGE-YEARS आयु-वर्ष	3YEARS
SEX लिंग	FEMALE
FATHER'S/SPOUSE'S NAME पिता/पति/पत्नी का नाम	SUNNY (FATHER)
PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता	WZ2/T, HUTS, JJ COLONY, RAGHUBIR NAGAR, TAGORE GARDEN, DELHI-110027
PERMANENT RESIDENCE ADDRESS स्थाई आवासीय पता	
OCCUPATION व्यवसाय	HAWIKER (FATHER)
MARRIED (Yes/No) / UNMARRIED (Yes/No)	NA
TOTAL ANNUAL INCOME कुल वार्षिक आय	90,000 (FATHER) (Attach Proof of income) (आय का प्रमाण संलग्न करें)
PAN No. पैन संख्या (यदि)	
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable) क्या आप आय कर दाता हैं (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 सदस्य का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ संबंध
1.	SUNNY	29	MALE	FATHER
2.	NISHA	25	FEMALE	MOTHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिए किसी आधार

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय 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 किसी का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached समस्या/रोगों से जारी की गई प्रतिवेदन सूची संलग्न
1	DIAGNOSIS- RETINOBLASTOMA
2	PROCEDURE- EUA

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

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
	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 & [illegible] 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 [illegible] for which this assistance is requested.

1) मैं घोषणा करता हूँ कि इस प्रपत्र में दिये गए सभी विवरण मेरी जानकारी के अनुसार सत्य [illegible]

2) मैं इस बात का आश्वासन देता हूँ कि "कोशिका फाउन्डेशन" [illegible]

3) मैं पुष्टि करता हूँ कि [illegible]

AGREEMENT by APPLICANT (आवेदक द्वारा [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/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) इस प्रपत्र पर अपने हस्ताक्षर [illegible] "कोशिका फाउन्डेशन" [illegible]

[illegible]

2) मैं (आवेदक) [illegible]

"कोशिका" द्वारा इसके न्यासियों का निर्णय अंतिम और बाध्यकारी होगा।

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

[signature]

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.

हमारे अधिकृत हस्ताक्षरी [illegible] "कोशिका फाउन्डेशन" [illegible]

1) [illegible] "कोशिका फाउन्डेशन" [illegible]

2. "कोशिका फाउन्डेशन" [illegible]

[illegible] "कोशिका" की कोई भूमिका या जिम्मेदारी इस मामले में नहीं होगी।

RECOMMENDED FOR ACCEPTENCE
स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख		
17/1/24	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services (Name of Dr. & Reg. No. 100745 with Stamp) 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 on behalf of Hospital) Dr. Shroff's Charity Eye Hospital

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]

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

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

30th November 2024

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby. Khushi- E/1124/0241

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

Name		Baby. Khushi	**Address/ Phone:**	W2/T , Huts-100,JJ colony , Raghubir nagar, Tagore garden, Delhi-110027	
MR N		DEL-G-24-02-5893	**Age/Sex**	3 years	Female
S. No	**Treatment date**	**Items**	**Cost per Unit**	**No. of unit**	**Aprox. Cost**
1	17/11/2024	Chemotherapy	2500	1	2500
2	17/11/2024	EUA(Examination under Anesthesia)	2000	1	2000
		Total			**4500**

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL
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E-mail : sceh@sceh.net, Website : www.sceh.net
OTHER CENTRES