SRE-C-24-06-0706

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

Koshika foundation
Building block of life

PASTE PHOTO HERE

Pre op Post op
Syano (0258)

APPLICATION No. S/0624/0258

APPLICATION DATE 14-06-2024

NAME of APPLICANT Mrs. Syano

AGE-YEARS 69

SEX F

FATHER'S/SPOUSE'S NAME: Late Mr. Sukhpal

PRESENT RESIDENCE ADDRESS: 147, Najaf, Najaf Nali, Shamli, Uttar Pradesh - 247777

PERMANENT RESIDENCE ADDRESS: same as above

OCCUPATION Home Maker

MARRIED / UNMARRIED

TOTAL ANNUAL INCOME 48,000 (Family Income)

(Attach Proof of Income) NA

PAN No. NA

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)	Sunil	38	M	Son
(2)	Rati	36	F	Daughter in law
(3)	Radhika	19	F	Grand daughter
(4)	Shiva	16	M	Grand Son

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
	Diagnosis - RE- Senile Cataract LE- Senile Cataract Surgery - LE - SICS With PMMA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

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

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.

[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/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. 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 :
आवेदक के हस्ताक्षर या अंगूठे का निशान

p-Self

AGREEMENT by HOSPITAL (अस्पताल 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]

RECOMMENDED FOR ACCEPTENCE स्वीकृति के लिए संस्तुति		
Date of Surgery सर्जरी की तिथि 14-06-2024	Dr. AASTHA D[illegible] (Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. न.	ARNAB MODAK ADMINISTRATOR SCEH SAHARANPUR (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्ताक्षर 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]