

APPLICATION FORM FOR ASSISTANCE

(Healthcare)

(वैद्यकीय सहायता)

(आयुष्य-सहायता)



APPLICATION NO. (आयुष्य-सहायता नं.) E/0125/0326

APPLICATION DATE (आयुष्य-सहायता तिथि) 02/01/23

NAME OF APPLICANT (आयुष्य-सहायता नाम) ABU VAKAR

AGE-YEARS (आयु-वर्ष) 02 YEARS

SEX (लिंग) MALE

FATHER'S RESIDENCE NAME (पिता-निवास नाम) MONISH (FATHER)

PRESENT RESIDENCE ADDRESS (वर्तमान निवास पता)

VILLAGE SHADHPUR, DISTRICT MURAD
- ABAD, UTTAR PRADESH
34402

PERMANENT RESIDENCE ADDRESS (स्थायी निवास पता)



OCCUPATION (व्यवसाय) GLASS PAINTER (FATHER) MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME (कुल वार्षिक आय) 1,44,000 (FATHER) (आयुष्य-सहायता प्रमाण)

PAN No. (आयुष्य-सहायता नं.)

ARE YOU AN INCOME TAX RESIDENT? (आयुष्य-सहायता निवासी है या नहीं?)

Yes / No
हाँ / नहीं

FAMILY DETAILS (परिवार विवरण)

Sr. No. (आयुष्य-सहायता क्र.सं.)	Name of Family Member (परिवारिक सदस्य का नाम)	Age (Years) (आयु-वर्ष)	Gender (लिंग)	Relation with Applicant (आयुष्य-सहायता संबंध)
1	MONISH	25	MALE	FATHER
2	TAJ ZAHN	32	FEMALE	MOTHER
3	ABUZAR	03	MALE	BROTHER

BASIS for REQUESTING ASSISTANCE (आयुष्य-सहायता निवेदन के आधार पर)

PH Card (आयुष्य-सहायता कार्ड) यदि यह है तो आवेदन में आयुष्य-सहायता नं. के साथ जोड़ा जाये	EMR Card (आयुष्य-सहायता कार्ड) यदि यह है तो आवेदन में आयुष्य-सहायता नं. के साथ जोड़ा जाये	Phone Card (आयुष्य-सहायता कार्ड) यदि यह है तो आवेदन में आयुष्य-सहायता नं. के साथ जोड़ा जाये	Any Other (आयुष्य-सहायता प्रमाण) यदि यह है तो
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"PURPOSE" for REQUESTING ASSISTANCE (आयुष्य-सहायता निवेदन का उद्देश्य)

Sr. No. (आयुष्य-सहायता क्र.सं.)	Medical Reports/Prescriptions Attached (आयुष्य-सहायता प्रमाण के साथ जोड़ा जाये)
1	DIAGNOSIS - PETIOBLASTOMA
2	TREATMENT - FUA

ASSISTANCE BEING AWARDED for SAME "PURPOSE" from OTHER SOURCES
(आयुष्य-सहायता निवेदन के लिए समान उद्देश्य के लिए अन्य स्रोतों से आर्थिक सहायता मिल रही है या नहीं?)

NO

Sr. No. (आयुष्य-सहायता क्र.सं.)	NAME of OTHER SOURCE (आयुष्य-सहायता स्रोत का नाम)	AMOUNT of ASSISTANCE BEING AWARDED (आयुष्य-सहायता निवेदन का राशि)
	NA	

DECLARATION by APPLICANT: (पत्रक 20) कृपया पढ़ें:

- (1) I hereby declare that all papers in this form are true to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, liable for discontinuation.
- (2) I hereby declare that assistance, if received from Koshika Foundation, will be exclusively for the "purpose", as stated in this form, for which such assistance was requested by me.
- (3) I hereby declare that I have not & will not in future, avail of reimbursement, in part or total, from any other source/employer/insurance company of the amount for which the assistance is requested.
- (4) I declare that if I am aware of this will with future at present or upon any of the time will have no more money and may if it is not aware that it is not.
- (5) I declare that "affirmative" is not a part of, your name will not be put in the form, which is not a part of the form.
- (6) I declare that if the form is not a part of the form, it is not a part of the form and will not be a part of the form.

AGREEMENT by APPLICANT: (पत्रक 20) कृपया पढ़ें:

(1) By affixing my signature or thumb impression on this form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/authorize to use my name, address, photo & details of the "purpose", for which such assistance is requested/needed, through any medium including but not limited to verbal, print, electronic, for spreading awareness for Koshika Foundation and/or disseminating information about its activities/programmes. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfillment 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/needed, 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.

(3) I declare that I am aware of this will with future at present or upon any of the time will have no more money and may if it is not aware that it is not.

(4) I declare that "affirmative" is not a part of, your name will not be put in the form, which is not a part of the form.

(5) I declare that if the form is not a part of the form, it is not a part of the form and will not be a part of the form.

(6) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/needed, 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.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

(पत्रक 20) कृपया पढ़ें:

MANISH (FATHER)

AGREEMENT by HOSPITAL: (पत्रक 20) कृपया पढ़ें:

By affixing her/his signature or our authorized signatory for recommending the cooperation 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 purpose(s), as we are requesting to get from Koshika Foundation, or the subject that such assistance is granted by Koshika Foundation. If the requested assistance is not granted by Koshika Foundation, in part or in full, from 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 purpose(s) from any other NGO or any other source.

(2) The assistance from Koshika Foundation is only financial in nature. The choice of the recommended/patient who is recommended by the Hospital on the subject, is based on the arrangement between the patient & the Hospital, and is in no way influenced by Koshika Foundation. Hence, the Hospital will assume full & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in this regard.

I hereby declare that I am aware of this will with future at present or upon any of the time will have no more money and may if it is not aware that it is not.

(3) I declare that "affirmative" is not a part of, your name will not be put in the form, which is not a part of the form.

(4) I declare that if the form is not a part of the form, it is not a part of the form and will not be a part of the form.

(5) I declare that if the form is not a part of the form, it is not a part of the form and will not be a part of the form.

(6) I (Applicant) further agree that any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/needed, 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.

RECOMMENDED FOR ACCEPTANCE:

Dr. CHHAVI GUPTA

Adjunct Consultant,
Gynaecology and Obstetrics Services
Regd. No. 500745

Dr. Chhavi Gupta has registered
(Name of Dr. & Regd. No. with Stamp)
अंतर का का र अंतर का र (रि. नं.)

Dr. SUDANSHU
Director

Surgeons and Clinical Research Services
Director, Medical Education Department
Regd. No. 00281

(Name, Designation & Stamp of Authorized Signatory
on behalf of Hospital)
नाम व पद अंतर का र अंतर का र

Date of Surgery
चर्चा की तिथि
07/01/25

FOR INTERNAL USE of KOSHIKA FOUNDATION: (पत्रक 20) कृपया पढ़ें:

SIGNATURE of TRUSTEE I
नाम अंतर का र

Safar

SIGNATURE of TRUSTEE II
नाम अंतर का र

Dr. R. B.



Dr. Shroff's Charity Eye Hospital

Serving for the continuously since 1927.

30th January 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital

Please find below attached estimate expenditure of Mast. Abu Vahar E/0125/0326



Dr. Shroff's Charity Eye Hospital
Gurgaon New Ambience

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital Retinoblastoma Surgery					
Name		Mast. Abu Vahar	Address Phone	Village Chhapra, District Meerut, Uttar Pradesh-244402	
MR N		DEL-P-23-03-1902	Age/Se	2 years	Male
S. No.	Treatment Date	Item	Cost per Unit	No. of unit	Approx. Cost
1	2025-01-27	EUA	2000	1	2000
		Total			2000

Best Regards

Dr. Sima Das

Director

Ophthalmology and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL

5027, Kedar Nath Road Daryaganj, New Delhi-110002 India

Ph: 011-4352 4444, 4352 5555, Fax: 011-43525815

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

OTHER CENTRES

ALWAR • SAHARANPUR • MEERUT • LAKHIMPUR KHURJ • VARANASI • KANUNGI (DELHI) • MODI NAGAR • RANIKHET