DEL-P-23-03-1902

APPLICATION FORM FOR ASSISTANCE (Healthcare)

Koshika foundation

APPLICATION No.	E / 0125 / 0326
APPLICATION DATE	02/01/25
NAME of APPLICANT	ABU VAKAR
AGE-YEARS	02 YEARS
SEX	MALE
FATHER'S/SPOUSE'S NAME	MONISH (FATHER)

PRESENT RESIDENCE ADDRESS

VILLAGE SHAHPUR, DISTRICT MURAD-ABAD, UTTAR PRADESH 24402

PERMANENT RESIDENCE ADDRESS

OCCUPATION	GLASS PAINTER (FATHER)
MARRIED / UNMARRIED	
TOTAL ANNUAL INCOME	1,44,000 (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	MONISH	35	MALE	FATHER
2	TANZEEN	32	FEMALE	MOTHER
3	ABUZAR	03	MALE	BROTHER

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 : [illegible]

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 ([illegible])

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its Trustees to [illegible] my name, address, photo & details of the "purpose" for which such assistance is requested/granted, through any [illegible] for soliciting donations for Koshika Foundation and/or disseminating information about its activities/achievements. [illegible]

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 :

[illegible]

MONISH (FATHER)

AGREEMENT by HOSPITAL ([illegible])

By affixing [illegible] 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. [illegible]

2) The assistance from Koshika Foundation is only financial in nature. [illegible]

[illegible]

RECOMMENDED FOR ACCEPTENCE

[illegible]

Date of Surgery [illegible]	Dr. CHHAVI GUPTA Adjunct Consultant, [illegible] Oncology Services Regd. No. 100745 Dr. [illegible] Eye Hospital (Name of Dr. & Regn. No. with Stamp) [illegible]	Dr. [illegible] Director [illegible] Regd. No. [illegible] Name, Designation & Stamp of Authorised Signatory on behalf of Hospital [illegible]
07/01/25		

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

SIGNATURE of TRUSTEE 1 [illegible]	SIGNATURE of TRUSTEE 2 [illegible]
[signature]	[signature]

18-08-2024

Dr. Shroff's Charity Eye Hospital

Caring for the community since 1923...

Dr. Shroff's Charity Eye Hospital
Delhi (A New NABH Accredited)

31st January 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

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

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital Retinoblastoma Surgeries					
Name		Mast. Abu Vakar	Address/ Phone:	Village Shahpur, District Moradabad, Uttar Pradesh- 244402	
MRN		DEL-P-23-03-1902	Age/Sex	2 years	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Approx Cost
1	2025-01-07	EUA	2000	1	2000
		Total			2000

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services