

DEL-G-24-03-5504

APPLICATION FORM FOR ASSISTANCE
(आवेदन फार्म सहायता के लिए)(Healthcard)
(स्वास्थ्य कार्ड)Koshika
Foundation
Creating Health in IndiaAPPLICATION NO.
(आवेदन संख्या)

E/0125/0331

APPLICATION DATE
(आवेदन तिथि)

01/01/25

NAME of APPLICANT
(आवेदक का नाम)

MOHD HASAN

AGE (Years)

03 YEARS

SEX

MALE

FATHER/MOTHER'S NAME
(पिता/माता का नाम)

ALI MOHD (FATHER)

PRESENT RESIDENTIAL ADDRESS (House No.)

VILLAGE KHURA, KHERI, UTTAR PRADESH - 202301

PERMANENT RESIDENTIAL ADDRESS (House No.)

OCCUPATION
(व्यवसाय)

LABOURER (FATHER)

(Annual Income) / (वार्षिक आय)

TOTAL ANNUAL INCOME
(कुल वार्षिक आय)

1,20,000 (FATHER)

(When Filled up by you)
(जब आप इसे भरेंगे)

FORM No. 102 (REV. 2019)

ARE YOU/ANYONE ELSE SUFFERING FROM ANY OTHER DISEASE?
(क्या आप या कोई अन्य व्यक्ति किसी अन्य रोग से ग्रस्त हैं?)Yes / No
हाँ / नहीं

FAMILY DETAILS (Other than)

Sl. No. (सं. क्र.)	Name of Family Member (आपके परिवार के सदस्य का नाम)	Age (Years) (वय (वर्ष))	Gender (लिंग)	Relation with Applicant (आवेदक से संबंध)
1	ALI MOHD	45	MALE	FATHER
2	JAMILA	36	FEMALE	MOTHER
3	SHERBANO	08	FEMALE	SISTER
4	MO. HUSSAIN	04	MALE	BROTHER

REASON for REQUESTING ASSISTANCE (The illness is a) (वैद्यकीय कारण)

1. ICD Code (आवश्यक कोड) (आवश्यक कोड)	2. ICD Code (आवश्यक कोड) (आवश्यक कोड)	3. ICD Code (आवश्यक कोड) (आवश्यक कोड)	4. ICD Code (आवश्यक कोड) (आवश्यक कोड)
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PURPOSE for REQUESTING ASSISTANCE
(आवेदन करने का उद्देश्य)

Sl. No. (सं. क्र.)	Medical Reports/Prescriptions Attached (आवश्यक रिपोर्ट/प्रेस्क्रिप्शन)
1	DIAGNOSIS - RETINOBLASTOMA
2	TREATMENT - ECA, CHEMOTHERAPY

ASSISTANCE BEING REQUESTED for SAME PURPOSE as OTHER SOURCES
(सहायता के लिए समान उद्देश्य के लिए अन्य स्रोतों से)

No / Yes

Sl. No. (सं. क्र.)	NAME of OTHER SOURCE (अन्य स्रोत का नाम)	AMOUNT of ASSISTANCE BEING REQUESTED (आवेदन की राशि)
1	NA	

DECLARATION BY APPLICANT (please print name)

- I hereby declare that all details in this form are true to the best of my knowledge. My name, address and contact details are correct and up-to-date. I am fully aware of the consequences of providing false information.
- I understand that the assistance provided by Koshina Foundation will be subject to the "guidelines" as stated in the form for which such assistance was requested by me.
- I hereby declare that I have not & will not provide any of my personal or professional information to any other person or organization for the purpose of obtaining financial assistance from any other source.
- I declare that I am not a member of any political party or organization, nor am I a member of any religious or social organization, nor am I a member of any trade union or other organization.
- I declare that I am not a member of any political party or organization, nor am I a member of any religious or social organization, nor am I a member of any trade union or other organization.
- I declare that I am not a member of any political party or organization, nor am I a member of any religious or social organization, nor am I a member of any trade union or other organization.

AGREEMENT BY APPLICANT (please print name)

- I hereby agree to the following conditions of the assistance provided by Koshina Foundation and its Trustees for the purpose of supporting my family, education, health & needs of the "patient". The assistance provided is requested through my request, including but not limited to, medical, dental, financial, and other assistance for Koshina Foundation's assistance. I understand that the assistance provided is subject to the "guidelines" as stated in the form for which such assistance was requested by me.
- I (Applicant) further agree that any use of my name, signature, photo & image of the "patient" 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 Koshina Foundation, and their decision in this regard will be final and irrevocable to me.
- I agree to use the assistance provided for the purpose of the "patient" and not for any other purpose. I agree to use the assistance provided for the purpose of the "patient" and not for any other purpose. I agree to use the assistance provided for the purpose of the "patient" and not for any other purpose.
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APPLICANT'S SIGNATURE OR LEGAL GUARD SIGNATURE

(please print name)

 **RT**
(Mother) **Samela**

AGREEMENT BY HOSPITAL (please print name)

- I hereby agree to the following conditions of the assistance provided by Koshina Foundation and its Trustees for the purpose of supporting my family, education, health & needs of the "patient". The assistance provided is requested through my request, including but not limited to, medical, dental, financial, and other assistance for Koshina Foundation's assistance. I understand that the assistance provided is subject to the "guidelines" as stated in the form for which such assistance was requested by me.
- I (Hospital) further agree that any use of my name, signature, photo & image of the "patient" 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 Koshina Foundation, and their decision in this regard will be final and irrevocable to me.
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RECOMMENDATION FOR ACCEPTANCE

(please print name)

Dr. URMIL DAS

Director

Orthodontics and Dental Surgery Services

Director, Medical Education Department

Page No. 00291

(North, Coimbatore & South India)

(on behalf of Hospital)

(please print name)

Date of Surgery

(please print date)

03/01/25

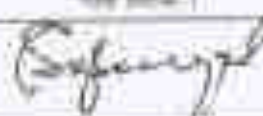
Dr. CHANDRA GUPTA
Adjunct Consultant,
Oral and Maxillofacial Surgery
Page No. 100745
Dr. Manoj Kumar Singh
(please print name)



FOR INTERNAL USE OF KOSHINA FOUNDATION (please print name)

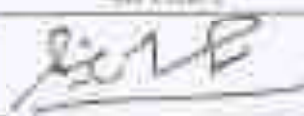
SIGNATURE OF TRUSTEE 1

(please print name)



SIGNATURE OF TRUSTEE 2

(please print name)





Dr. Shroff's Charity Eye Hospital

Caring for the community since 1922

31st January, 2023

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital

Please Find below attached estimate expenditure of Mstr. Mohd Hasan- E/0125/0131



Dr. Shroff's Charity Eye Hospital
Charity is how Nation is sustained

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital Rajiv Gandhi Cancer Institute					
Name		Mstr. Mohd Hasan	Address & Phone	Village Khura, Khari, Uttar Pradesh- 202701	
MR N		DEL-G-24-03-5504	Age/Se x	3 years	Male
S. No.	Treatment date	Service	Cost per Unit	No. of Unit	Approx Cost
1	2025-01-01, 2025- 01-01	CEJA	2000	2	4000
2	2025-01-01, 2025- 01-01	Chemo	2500	2	5000
		Total			9000

Best Regards

Dr. Soma Das

Director

Oncoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL

5027, Kedar Nath Road Daryaganj, New Delhi-110032 India

Ph- 011-4352 4444, 4352 8888, Fax : 011-43528810

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

OTHER CENTRES

ALWAR • BAHARANPUR • DEHRADUN • LAKHIMPUR KHURI • MUMBAI • KAROL BAGH (DELHI) • MODI NAGAR • RAIPUR