DEL-4-19-07-2354

APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रपत्र

Koshika Foundation

APPLICATION No.	E / 0125 / 0335
APPLICATION DATE	02/01/25
NAME of APPLICANT	SHAILESH PAUDEL
AGE YEARS	07 YEARS
SEX	MALE
FATHER'S/SPOUSE'S NAME	RAMESH KR PAUDEL (FATHER)
PRESENT RESIDENCE ADDRESS	NEPAL - DANG, WARD NO. - 10
PERMANENT RESIDENCE ADDRESS	
OCCUPATION	LABOURER (FATHER)
MARRIED / UNMARRIED	
TOTAL ANNUAL INCOME	72,000 (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	RAMESH KR PAUDEL	41	MALE	FATHER
2	NAMUNA CHAPAIN	38	FEMALE	MOTHER
3	SHUBHADRA	69	FEMALE	GRANDMOTHER
4	BHAWANA	12	FEMALE	SISTER

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/hospital/employer/insurance company, of the amount for which this assistance is requested.

[illegible]

[illegible]

[illegible]

AGREEMENT by APPLICANT [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/publicise/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.

[illegible]

[illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :
[illegible]

(FATHER)

AGREEMENT by HOSPITAL [illegible]

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 specifically 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]

[illegible]

[illegible]

RECOMMENDED FOR ACCEPTENCE [illegible]		
Date of Surgery [illegible] 04/1/25	Dr. CHHAVI GUPTA Adjunct Consultant, Oculoplasty and Ocular Oncology Services Regd. No. 100749 (Name of DC & Regn. No. with Stamp) [illegible]	Dr. [illegible] Director Oculoplasty and Ocular oncology services [illegible] Regd. No. [illegible] Dr. Shroff's Charity Eye Hospital (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

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

11-04-2024

Dr. Shroff's Charity Eye Hospital

Caring for the community since 1922.

Dr. Shroff's Charity Eye Hospital
Delhi by New NABH Accredited

31st January 2025

Dear Mr. Tarutish

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Mr. Shailesh Pandal- E/0123/0335

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

Name		Mr. Shailesh Pande	Address of Phone	Ward no. 10 Nepal Ganj	
MR N		DEL-G-19-07-2354	Age/Sex	1 years	Male
S. No	Treatment date	Items	Cost per Unit	No. of unit	Aprox Cost
1	2025-01-09	EUA	2000	1	2000
		Total			2000

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services