

0-22-04-0757

APPLICATION FORM FOR ASSISTANCE (Healthcare)		Koshika foundation Building block of life.		
APPLICATION No.: <u>A/0722/0395</u>		APPLICATION DATE: <u>18/07/2022</u>		
NAME of APPLICANT: <u>Satyopal</u>		AGE-YEARS आयु-वर्ष: <u>37</u>	SEX लिंग: <u>M</u>	
FATHER'S/SPOUSE'S NAME: <u>Omkar</u>				
PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता				
Village- <u>Daksh Warg, Tapookhara, Teh.-</u>				
Tizwarg, Dist- <u>Alwar, Rajasthan- 301707</u>				
PERMANENT RESIDENCE ADDRESS: स्थाई आवासीय पता		Pre-op <u>0395</u> Post-op <u>Satyopal</u>		
As above				
OCCUPATION: <u>Farmer</u>		MARRIED (विवाहित) / UNMARRIED (अविवाहित)		
TOTAL ANNUAL INCOME: <u>50,000/-</u>		(Attach Proof of Income) (आय का साक्ष्य संलग्न) <u>NA</u>		
PAN No. स्थाई खाता संख्या <u>NA</u>				
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता है (जो मान्य हो उस पर सही का निशान लगाये)		Yes / No हां / नहीं		
FAMILY DETAILS परिवार विवरण				
Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ सम्बंध
(1)	<u>Manisha</u>	<u>37</u>	<u>F</u>	<u>wife</u>
(2)	<u>Saneesh</u>	<u>10</u>	<u>M</u>	<u>Son</u>
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये विनति आधार				
BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोक्ता कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य	
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किये गये विनतों का उद्देश्य:				
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न			
(1)	<u>Diagnosis RE - SENILE CATARACT</u> <u>LE - SENILE CATARACT</u>			
(2)	<u>Surgery - LE - PHACOEMULSION</u>			
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य को हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया हो?				
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशी		
(1)	<u>NA</u>			

DECLARATION BY APPLICANT: सत्यमेव जयते 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.		1) I affirm that I am not a member of any political party or organization, and I am not a member of any religious or caste-based organization. 2) I affirm that I am not a member of any organization that is engaged in any activity that is prohibited by the laws of India. 3) I affirm that I am not a member of any organization that is engaged in any activity that is prohibited by the laws of India.	
AGREEMENT BY APPLICANT (अर्हक प्र मय) 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its 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 its activities/achievements. 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/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. 3) I affirm that I am not a member of any political party or organization, and I am not a member of any religious or caste-based organization. 4) I affirm that I am not a member of any organization that is engaged in any activity that is prohibited by the laws of India.			
APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION: अर्हक प्र मय			
AGREEMENT BY HOSPITAL (हस्पताल प्र मय) By affixing hereunder, signature of our Authorized Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we assume sole & complete responsibility of the treatment & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. 1) We affirm that we are not a member of any political party or organization, and we are not a member of any religious or caste-based organization. 2) We affirm that we are not a member of any organization that is engaged in any activity that is prohibited by the laws of India. 3) We affirm that we are not a member of any organization that is engaged in any activity that is prohibited by the laws of India.			
RECOMMENDED FOR ACCEPTANCE हस्पताल प्र मय			
Date of Surgery 18/7/22 अर्हक प्र मय		DR. WAFIANSARI MS (OPHTHAL) Reg. No. DMC/83199 (Name of Dr. & Regn. No. with Stamp) अर्हक प्र मय	
CHARAN MASSEY Authorized Signatory of Hospital (Name, Designation, Title of Hospital) अर्हक प्र मय		FOR INTERNAL USE OF KOSHIKA FOUNDATION अर्हक प्र मय	
SIGNATURE OF TRUSTEE 1 अर्हक प्र मय		SIGNATURE OF TRUSTEE 2 अर्हक प्र मय	