

C-22-09-0387

APPLICATION FORM FOR ASSISTANCE (Healthcare) सहायता हेतु आवेदन प्रारूप		Koshika foundation Building block of life.		
APPLICATION No.: आवेदन संख्या: A/0922/0533		APPLICATION DATE: 12-09-2022 आवेदन तिथि		
NAME of APPLICANT: आवेदक का नाम Mahamudi		AGE-YEARS आयु-वर्ष 70	SEX लिंग F	
FATHER'S/SPOUSE'S NAME: पिता/कटुस्थ का नाम Isak		 Preop 0533 Postop Mahamudi		
PRESENT RESIDENCE ADDRESS वर्तमान आवास पता Village- Chulwanda Teh.- Tizara Dist.- Alwar Rajasthan-301007				
PERMANENT RESIDENCE ADDRESS स्थाई आवास पता As above				
OCCUPATION: व्यवसाय Home maker				
TOTAL ANNUAL INCOME: कुल वार्षिक आय 56,000/- [Family]		MARRIED (विवाहित) / UNMARRIED (अविवाहित) (Attach Proof of Income) (आय का साक्ष्य संलग्न) NA		
PAN No. स्थाई खाता संख्या NA				
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (ओ मान्य हो उस पर सही का निशान लगावें)		Yes (हाँ) / No (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	Tshek	68	m	Husband
②	Toyeh	39	m	Son
③	Roshan	37	F	Daughter in law
④	Aniraj	19	m	Grand Son
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये चिन्हित 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)		Any Other Basis/Proof अन्य कोई साक्ष्य
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किये गये चिन्हों का उद्देश्य:				
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न			
①	Diagnosis RE - SENILE FURROW DEGENERATION LE - SENILE FURROW DEGENERATION			
②	Surgery - LE - SICS WITH PMMA			
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य के 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		
③	Nil			

12/9/22 Date of Surgery सर्जरी की तिथि		DR. WAFI ANSARI MS (OPHTHAL) Reg. No.-DMC/93199 (Name of Dr. & Reg. No. with Stamp) डॉ. वाफ़ी अंसारी एम.एस. (आँखों की रोगों का विशेषज्ञ) रजि. नं. डी.एम.सी./93199		Dr. Shroff's Eye Hospital Adminstrator CHARAN MASSEY (Name, Designation & Stamp of Authorised Signatory) डॉ. श्रोफ़्स आँखों के अस्पताल आचार्य चरान मासेय	
FOR INTERNAL USE OF KOSHKA FOUNDATION आंतरिक उपयोग के लिए					
SIGNATURE OF TRUSTEE 1 हस्ताक्षर 1		SIGNATURE OF TRUSTEE 2 हस्ताक्षर 2			
RECOMMENDED FOR ACCEPTANCE स्वीकृति के लिए सिफ़ारिश					
By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we assume sole & complete responsibility of the treatment & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. (हस्ताक्षर) हमारे द्वारा स्वीकृत/अस्वीकृत करने वाले अधिकृत हस्ताक्षरकर्ता की स्वीकृति के बिना, हम इस मामले में पूर्ण और पूर्णतः ज़िम्मेदार होंगे। 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 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 patient/case from any other NGO or any other source. 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 & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. 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 & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. 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 was requested by me. 4) 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 is liable for rejection/cancellation. 5) 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.					
DECLARATION BY APPLICANT: सच कहें हमें					
AGREEMENT BY APPLICANT (सहमति देना)					
1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/publish/print/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 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 is this regard will be final and acceptable to me. 3) 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 is this regard will be final and acceptable to me. 4) 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 is this regard will be final and acceptable to me. 5) 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 is this regard will be final and acceptable to me.					
APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION : आधारकर्ता की हस्ताक्षर या बायाँ 엄지 انگूश का छाप					
AGREEMENT BY HOSPITAL (हमारे द्वारा सहमति)					