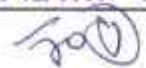


C-2210-0453

APPLICATION FORM FOR ASSISTANCE (Healthcare) सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)		Koshika foundation Building block of life		
APPLICATION No. : आवेदन संख्या :	A/1022/0680	APPLICATION DATE : 14-10-2022 आवेदन तिथि		
NAME of APPLICANT : आवेदक का नाम	Phaiman	AGE-YEARS आयु-वर्ष 64		
		SEX लिंग F		
FATHER'S/SPOUSE'S NAME : पिता/कटुम्ब का नाम	Hajar Khan			
PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता				
Village - Raipur, Teh - Tijara, Dist - Alwar				
Rajasthan - 301011				
PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता				
As above				
OCCUPATION : व्यवसाय	Home maker (family)	MARRIED (विवाहित) / UNMARRIED (अविवाहित)		
TOTAL ANNUAL INCOME : कुल वार्षिक आय	50000	(Attach Proof of Income) (आप 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 (जो मान्य हो उस पर सही का निशान लगाएं)				
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 सम्बन्ध
1.	Hajar	70	m	Husband
2.	Umardeen	28	m	Son
3.	Rasmudeen	26	m	Son
4.	Allu	24	m	Son
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 विनती का उद्देश्य:				
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न			
1	Diagnosis RE - SENILE CATARACT LE - SENILE CATARACT			
2	Surgery - RE - 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		
1	Nil			



Preop Postop
0680 Phaiman

DECLARATION BY APPLICANT: 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, void. 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. 2) 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. 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.		AGREEMENT BY APPLICANT (सहसहकृता द्वारा कर्तव्य) 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/publish/put-up/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 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.	
APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:		AGREEMENT BY HOSPITAL (हॉस्पिटल द्वारा कर्तव्य) 	
By affixing hereunder, signature of our Authorized 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 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 & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. (2) That 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 & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. (3) That 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 & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.			
RECOMMENDED FOR ACCEPTANCE 		Date of Surgery: 15/10/22 Dr. Wafi Ansari MS (OPHTHAL) Reg. No. DMC-93199 (Name of the Hospital/Institution) Dr. Shroffs Eye Hospital, Alwar	
FOR INTERNAL USE OF KOSHIKA FOUNDATION Signature of Trustee 1 Signature of Trustee 2		Date of Surgery: 15/10/22 Dr. Wafi Ansari MS (OPHTHAL) Reg. No. DMC-93199 (Name of the Hospital/Institution) Dr. Shroffs Eye Hospital, Alwar	