


C-22-11-1041

APPLICATION FORM FOR ASSISTANCE सहायता हेतु आवेदन प्रारूप		(Healthcare) (स्वास्थ्य देखभाल)		 Koshika foundation Building block of life.	
APPLICATION No. : आवेदन संख्या : A/1122/0799		APPLICATION DATE : 21-11-2022 आवेदन तिथि			
NAME of APPLICANT : आवेदक का नाम Prem		AGE-YEARS आयु-वर्ष 70	SEX लिंग F		
FATHER'S/SPOUSE'S NAME : पिता/कटुम्भ का नाम Dulli Chand					
PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता Village- Rabadka, Teh.- Tizara, DIST.- Alwar Rajasthan - 301707					
PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता As above					
OCCUPATION : व्यवसाय Home maker (family)		MARRIAGE (विवाहित) / UNMARRIED (अविवाहित)			
TOTAL ANNUAL INCOME : कुल वार्षिक आय 56,000/-		(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 (जो मान्य हो उस पर सही का निशान लगायें)		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 सम्बन्ध	
1.	Dulichand	75	M	Husband	
2.	Mukesh	38	M	SON	
3.	Lakshmi	36	F	Daughter in law	
4.	Sumit	16	M	Grand son	
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये विनिर्दिष्ट 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 निम्नलिखित उद्देश्य:					
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न				
1	DIAGNOSIS RE - PSC LE - PSC				
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 है?					
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि			
1	Nil				



Postop
0799

Postop
Prem

[Handwritten Signature]

SIGNATURE OF TRUSTEE 1

[Handwritten Signature]

SIGNATURE OF TRUSTEE 2

FOR INTERNAL USE OF KOSHIKA FOUNDATION

21/11/22
Date of Surgery

Dr. WAFI ANSARI
MS (OPHTHAL)
Reg No. DM/63199
(Name of Regd. Specialist)

Charan Massey
Admission & Stamp of Authorized Signatory
Dr. Shrotra (on behalf of Hospital)

RECOMMENDED FOR ACCEPTANCE

[Handwritten Signature]

By affixing hereunder, signature of our Authorized Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we agree that we are not 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 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.

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 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) 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) 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.

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 was requested by me.

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.

6) 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.

7) 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 HOSPITAL (प्रमाणित किया गया)

[Handwritten Signature]
R.T
Pran Dev

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :

1) By affixing my signature or thumb impression on this Form, (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) (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 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.

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 was requested by me.

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AGREEMENT BY APPLICANT (आवेदक द्वारा स्वीकृति)

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.

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