

AWR-C-23-01-0619

APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप(Healthcare)
(स्वास्थ्य देखभाल)Koshika
foundation

APPLICATION No.:

आवेदन संख्या:

A/0123/1060

APPLICATION DATE:

आवेदन तिथि

19-01-2023

NAME of APPLICANT:

आवेदक का नाम

Bhairy Baks Gunjar

AGE-YEARS आयु-वर्ष

75

SEX लिंग

M

FATHER'S/SPOUSE'S NAME:

पिता/कटुम्ब का नाम

Thurtha Ram Gunjar

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

Village - Ranspur

Teh - Ranspur

Dist - Alwar

Rajasthan - 301402

PERMANENT RESIDENCE ADDRESS: स्थाई आवासीय पता

as above.



PreOP

1060

PostOP

Bhairy
Baks
Gunjar

OCCUPATION:

व्यवसाय

Farmer

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME:

कुल वार्षिक आय

50,000

(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 शता है (जो मान्य हो उस पर सही का निशान लगाये।)

Yes (No)

हाँ / 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)	Rama	70	F	Wife
(2)	Railash	40	M	Son
(3)	Gunjara	41	F	daughter in law
(4)	Haram	15	M	Grand Son

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिये विनति आधार

BPL Card (Attach Card Copy) गरीबी रेषा 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
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"PURPOSE" for REQUESTING ASSISTANCE:

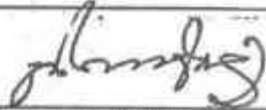
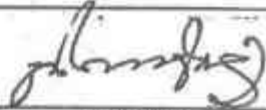
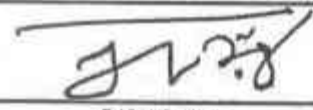
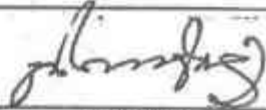
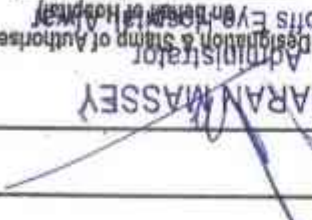
सहायता हेतु किये गये विनती का उद्देश्य:

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 - SICF 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	

DECLARATION by APPLICANT: 		SIGNATURE OF TRUSTEE 1 	
SIGNATURE OF TRUSTEE 2 		SIGNATURE OF TRUSTEE 1 	
FOR INTERNAL USE OF KOSHIKA FOUNDATION			
Date of Surgery 20/11/23		MS (OPHTHAL) Dr. WAFI ANSARI Reg. No. DMO/31990 (Stamp) (Name of Doctor & Hospital & Reg. No.)	
Date of Surgery 20/11/23		MS (OPHTHAL) Dr. WAFI ANSARI Reg. No. DMO/31990 (Stamp) (Name of Doctor & Hospital & Reg. No.)	
Date of Surgery 20/11/23		MS (OPHTHAL) Dr. WAFI ANSARI Reg. No. DMO/31990 (Stamp) (Name of Doctor & Hospital & Reg. No.)	
RECOMMENDED FOR ACCEPTANCE 			
(Name, Designation & Stamp of Authorised Signatory) Charan Massey Director Koshika Foundation			
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 & 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 NGO or any other source. 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.			
AGREEMENT by HOSPITAL (Signature of Hospital)			
APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:			
(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-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) (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.			
(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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