

| APPLICATION FORM FOR ASSISTANCE<br>सहायता हेतु आवेदन प्रारूप                                                                                     |                                                                                                                      | (Healthcare)<br>(स्वास्थ्य देखभाल)                                                        |                                           | <br><b>Koshika</b><br>foundation<br><small>Building block of life.</small> |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| APPLICATION No.: आवेदन संख्या : N 1012312221                                                                                                     |                                                                                                                      | APPLICATION DATE: आवेदन तिथि 24/1/23                                                      |                                           |                                                                                                                                                               |  |
| NAME of APPLICANT: आवेदक का नाम Ashirvadi                                                                                                        |                                                                                                                      | AGE-YEARS आयु-वर्ष 68                                                                     | SEX लिंग F                                |                                                                                                                                                               |  |
| FATHER'S/SPOUSE'S NAME: पिता/पत्न्य का नाम W/o putshotham                                                                                        |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| PRESENT RESIDENCE ADDRESS वर्तमान आवासस्थान पता<br>2nd cross christina colony Bangalore North Karnataka                                          |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| PERMANENT RESIDENCE ADDRESS स्थाई आवासस्थान पता<br>Same as above                                                                                 |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| OCCUPATION: व्यवसाय Home maker                                                                                                                   | MARRIED (विवाहित) / UNMARRIED (अविवाहित)                                                                             |                                                                                           |                                           |                                                                                                                                                               |  |
| TOTAL ANNUAL INCOME: कुल वार्षिक आय 10,500/-                                                                                                     | (Attach Proof of Income) (आय का साक्ष्य संलग्न)                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| PAN No. स्थाई खाता संख्या                                                                                                                        |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):<br>न्या आय कर दाता है (जो मान्य हो उस पर सही को निशान लगावे।) Yes / No हाँ / नहीं |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| FAMILY DETAILS परिवार विवरण                                                                                                                      |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| Sr. No.<br>क्रम संख्या                                                                                                                           | Name of Family Member<br>परिवार के सदस्यों का नाम                                                                    | Age (Years)<br>उम्र (वर्ष)                                                                | Gender<br>लिंग                            | Relation with Applicant<br>आवेदक के साथ सम्बन्ध                                                                                                               |  |
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| BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)<br>सहायता के लिये विनती आधार                                                      |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| BPL Card<br>(Attach Card Copy)<br>गरीबी रेषा के नीचे प्रमाण पत्र<br>(प्रमाण पत्र की छाया प्रति संलग्न करें।)                                     | EWS Certificate<br>(Attach Certificate Copy)<br>अल्प आय वर्ग प्रमाण पत्र<br>(प्रमाण पत्र की छाया प्रति संलग्न करें।) | Ration Card<br>(Attach Copy)<br>उपभोगका कार्ड<br>(प्रमाण पत्र की छाया प्रति संलग्न करें।) | Any Other Basis/Proof<br>अन्य कोई साक्ष्य |                                                                                                                                                               |  |
| "PURPOSE" for REQUESTING ASSISTANCE:<br>सहायता हेतु किसे गये विनती का उद्देश्य:                                                                  |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| Sr. No.<br>क्रम संख्या                                                                                                                           | Medical Reports/Prescriptions Attached<br>अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न                         |                                                                                           |                                           |                                                                                                                                                               |  |
| 1                                                                                                                                                | Diagnosis RF cataract<br>LE cataract                                                                                 |                                                                                           |                                           |                                                                                                                                                               |  |
| 2                                                                                                                                                | Surgery LE cataract + PCICL                                                                                          |                                                                                           |                                           |                                                                                                                                                               |  |
| ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES<br>इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया हो?            |                                                                                                                      |                                                                                           |                                           |                                                                                                                                                               |  |
| Sr. No.<br>क्रम संख्या                                                                                                                           | NAME of OTHER SOURCE<br>अन्य स्रोत का नाम                                                                            | AMOUNT of ASSISTANCE BEING AVAILED<br>लेई गई सहायता राशी                                  |                                           |                                                                                                                                                               |  |
| 1                                                                                                                                                | DBCS                                                                                                                 | 2000/-                                                                                    |                                           |                                                                                                                                                               |  |

## DECLARATION by APPLICANT: I/We hereby certify that the information furnished on this form is true and correct. I/We understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

- 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 Kashika 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) मैं घोषणा करता हूँ कि इस प्रमाणपत्र में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य कथन अथवा सत्य बात है तो मेरी सहमति निम्न की जा सकती है।
- 2) मैं घोषणा करता हूँ कि "उद्देश्य" (purpose) के अन्तर्गत, जो मेरी जानकारी के अनुसार सत्य एवं सही है, उसका उपयोग इसी उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रमाणपत्र में सत्य बात है।
- 3) मैं घोषणा करता हूँ कि मैं इस सहायता के लिए या भविष्य की कोई भी, उस सहायता का अधिक या समान विवरण किसी अन्य स्रोत/नियोक्ता/बीमा कम्पनी से न ले लिये है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (सहित छुवा कठोर)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and it's Trustees to use/publish/post-upreproduce 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 it's 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.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

आपके लिए भी हमारे पास है।



AGREEMENT by HOSPITAL (एस्पिटल डी अग्रीमेंट)

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 it's 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.
- 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 & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter.

## RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संस्तुति

Date of Surgery  
ऑपरेशन की तारीख

24/1/2023

**Dr. Laxmi Dorennavar**  
MBBS, MRCR, FRCR  
Consultant Radiologist & Ultrasound Specialist

Mr. Lakshmi pathi N  
Manager Outreach  
(Name, Designation & Stamp of Authorized Signatory  
(A unit of Government of Karnataka)  
on behalf of Hospital)

FOR INTERNAL USE of KOSHYLA FOUNDATION

आन्तरिक दायरे में

SIGNATURE of TRUSTEE 1  
 \_\_\_\_\_

SIGNATURE of TRUSTEE 2  
न्यायी हस्ताक्षर 2

Defendant

sent