

APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)

Koshika
foundation
Building block of life.

APPLICATION No. : K/0914/0847 APPLICATION DATE : 04.09.17

NAME of APPLICANT : SABITA DAS AGE-YEARS : 70 SEX : F

FATHER'S/SPOUSE'S NAME : KARTICK DAS

PRESENT RESIDENCE ADDRESS : 17C/H/4 GOBBAGAN STREET, KOLKATA, WEST BENGAL

PERMANENT RESIDENCE ADDRESS : AS ABOVE

OCCUPATION : HOUSE WIFE

TOTAL ANNUAL INCOME : NIL (Attach Proof of Income)

PAN No. : [Blank]

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): Yes / No

Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
1.	SABITA DAS	70	F	SELF
2.	SAYON DAS	42	M	SON
3.	KHAKON DAS	43	M	SON
4.	SIMA DAS	42	F	DAUGHTER
5.	SUSIMA DAS	38	F	DAUGHTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basis/Proof
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किसे गये निम्नी का उद्देश्य:

Sr. No.	Medical Reports/Prescriptions Attached
1.	DIAGNOSIS - CATARACT - LE
2.	SURGERY - LE (SIP & TOL)

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.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED
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