

C18/01/0106.

APPLICATION FORM FOR ASSISTANCE (Healthcare) (सहायता हेतु आवेदन प्रारूप)			Koshika foundation Building block of life.	
APPLICATION No.: आवेदन संख्या: ✓/0118/0735		APPLICATION DATE: आवेदन तिथि: 11/01/2018		
NAME of APPLICANT: आवेदक का नाम: Devi Singh		AGE-YEARS आयु-वर्ष: 68	SEX लिंग: M	
FATHER'S/SPOUSE'S NAME: पिता/कन्या का नाम: Sh. Charan Singh				
PRESENT RESIDENCE ADDRESS: वर्तमान निवास पता H.No → 64, VIII - Madhapura, Teh-Rupbas, Dist-Bharathpur				
PERMANENT RESIDENCE ADDRESS: स्थायी निवास पता same as above				
OCCUPATION: व्यवसाय: Farmer				
TOTAL ANNUAL INCOME: कुल वार्षिक आय: 2/000/-		(Attach Proof of Income) (आय का साक्ष्य संलग्न): NA		
PAN No. रमार्ड खाता संख्या				
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का चिह्न लगाएं): 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	Devi Singh	60	F	Wife
2	Charan Singh	30	M	Son
3	Devender	28	M	Son
4	Sataveer	25	M	Son
5	Manu	23	M	Son
6	Haradhar	20	M	Son
7	Sukhaver	18	F	Daughter
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के निम्न विधि आधार				
BPL Card (Attach Card Copy) गरीबी रेशा के पीछे प्रमाण पत्र (प्रमाण पत्र की छाया प्रिंट संलग्न करें)		EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रिंट संलग्न करें)		Ration Card (Attach Copy) उपभोक्तृ कार्ड (प्रमाण पत्र की छाया प्रिंट संलग्न करें)
Any Other Basis/Proof अन्य कोई साक्ष्य				
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किये गये विधियों का उद्देश्य:				
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न			
	RE → IMSC			
	LE → P.T			
	Surgery → (RE) SACS WITH IN			
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिये गया है?				
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम		AMOUNT of ASSISTANCE BEING AVAILED सी गई सहायता राशि	
1	S.C.E.H			



Preop Postop

(0735) Devi Singh

DECLARATION by APPLICANT: ज्ञातेवर: एतं धीरान्तरं यत्.

- 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 & my family 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 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, etc., for which this assistance is requested.
- 1) मैं यहाँ पर कह रहा हूँ कि इस प्रश्न में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य नहीं माना जाय तो मेरी सहायता निरस्त की जायेगी।
- 2) मैं यहाँ पर सत्यता पक्ष में "कोशिका फाउण्डेशन", से जो सहायता मिलेगी, उसका उपयोग केवल उद्देश्य को पूर्ण करने के लिये किया जायेगा, जो इस प्रश्न में भरा गया है।
- 3) मैं यहाँ पर कह रहा हूँ कि मैं किसी सहायता से या किसी अन्य स्रोत से इस सहायता के लिए पूरा या आंशिक रूप से क्षतिपूर्ति (रिबर्समेंट) नहीं करूँगा और न ही भविष्य में करूँगा।

AGREEMENT by APPLICANT (SEEKING TO RE-ENTER)

- 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:

आपेंकहि के हस्तक्षेप का खंडित भा निवारण

AGREEMENT by HOSPITAL (EASTMAN DS 602)

By affixing hereunder, signature of our Authorised 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.
- 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.

RECOMMENDED FOR ACCEPTANCE

रग्वीकृतौ यो लिपि संस्तुति

Date of Surgery
ऑपरेशन की तारीख

12/01/2018

Dr. Ashwini Kumar
MBBS, MS, FICO
Reg. No. 66028
Time.....
Date.....

(Name of Dr. & Regn. No. with Stamp)
 डाक्टर का नाम व दस्तावेज नं. के साथ

(Name, Designation & Stamp of Authorised Signatory
on behalf of Hospital)
नाम व पद हॉस्पिटल अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION अन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1
2nd FLOOR 1

SIGNATURE of TRUSTEE 2
नरसी इन्द्रधर 2