C18/11/0489

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

Koshika foundation
Building block of life

APPLICATION No.: आवेदन संख्या :	V/18/0856	APPLICATION DATE आवेदन तिथि	05/12/18
NAME of APPLICANT: आवेदक का नाम	Maya Devi	AGE-YEARS आयु-वर्ष: 71	SEX लिंग: F

FATHER'S/SPOUSE'S NAME: पिता/पति का नाम: D/O - Kishori Lal

PRESENT RESIDENCE ADDRESS: वर्तमान आवासीय पता
Tousi, Tonda, Salempur
Dist- Hathras U.P. 204102

PERMANENT RESIDENCE ADDRESS: स्थाई आवासीय पता
Same as above.

Preop Postop

(0856) Maya Devi

OCCUPATION: व्यवसाय: Housewife

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: कुल वार्षिक आय: NA

(Attach Proof of Income) (आय का साक्ष्य संलग्न) NA

PAN No. स्थाई खाता संख्या:

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता है (जो लागू हो उस पर सही का निशान लगायें): Yes / हां ✓ 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 संबंध
1	Dan Jal	late	m	Husband
2	Arjun	38	m	Son
3	Chandra prakash	32	m	Son

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिये किसी आधार

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आधारित प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई आधार

"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किये गये किसी का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached डाक्टर्स/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
	RE - TMAC
	IE - TMAC
	Surgery - (LE) SICS + IOL

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्त्रोत से लिया गया है?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
1	SCEH	

DECLARATION by APPLICANT: आवेदक द्वारा घोषणा पत्र

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 assista[nce] 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 as[sistance] 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 th[e] for which this assistance is requested.

1) मैं घोषणा करता हूँ कि इस प्रारूप में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही है। यदि कोई विवरण एवं कथन असत्य पाया जाता है तो मेरी सहायता निरस्त की जा स[illegible]
2) मेरे द्वारा जो सहायता राशि "कोशिका फाउंडेशन", से ली जा रही है, उसका उपयोग उसी उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रारूप में बताया गया है।
3) मैं पुष्टि करता हूँ कि जिस सहायता हेतु यह प्रार्थना की गई है, उस राशि का आंशिक या सकल हिस्सा किसी अन्य स्रोत/नियोक्ता/बीमा कम्पनी से न तो लिया है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to use/publish/put-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 it's activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfilment 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 is this regard will be final and acceptable to me.

1) इस प्रपत्र पर अपने हस्ताक्षर या अंगूठे की छाप लगाकर, मैं (आवेदक) अपनी सहमति की पुष्टि करता हूँ एवं "कोशिका फाउंडेशन और उसके न्यासीयों" को अधिकृत करता हूँ कि मेरा नाम, [illegible] "कोशिका फाउंडेशन" [illegible] अधिकृत है।
2) मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण [illegible] "कोशिका" एवम् उसके न्यासियों का निर्णय अंतिम और बाध्यकारी होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :
आवेदक के हस्ताक्षर या अंगूठे का निशान

AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

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 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.

[illegible] "कोशिका फाउंडेशन" [illegible]
1) [illegible]
2) "कोशिका फाउंडेशन" [illegible]

RECOMMENDED FOR ACCEPTENCE अधिकारी के लिए संस्तुति		
Date of Surgery सर्जरी की तारीख 05/12/018	Dr. Ashwini Kumar MBBS MS FICO Reg. No. 06028 Time Date (Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. न.	Shroff's Eye Care Institute, BHRC-Dr. ... Administrator (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2

28.04.2018