

C18/12/0209

APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)



APPLICATION No. : १/1218/0913 APPLICATION DATE : 11/12/018

NAME of APPLICANT : Sudha Rani AGE-YEARS : 60 SEX : F

FATHER'S/SPOUSE'S NAME : D/o - Ram Babu



PREP POSTOP
(0913) Sudha Rani

PRESENT RESIDENCE ADDRESS : Chroli Temple, Shirden Nagar, Tgla
DIST - Aligarh, UP, 202124
PERMANENT RESIDENCE ADDRESS : Same as above

OCCUPATION : Housewife

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME : NA

(Attach Proof of Income) NA

PAN No. : [Blank]

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):

Yes / No
हाँ / नहीं ✓

FAMILY DETAILS (परिवार विवरण)				
Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्य का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ सम्बन्ध
1	Ramchandra	63	M	Husband
2	Yagesh	32	M	Son
3	Aditya	32	M	Son
4	Neetu	30	F	Daughter
5	Rani	21	F	Daughter
6	Tahira	24	F	Daughter

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

BPL Card (Attach Card Copy) पोषी कार्ड के साथ प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	BWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोग्य कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई प्रमाण
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किसे लगे किसी का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached उपचार/दवाइयों के साथ की गई प्रमाणित दवाइयों
	RE - PP
	LE - T/MAL
	Surgery - (LE) S/CJ + IOL

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य को हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिये गए हैं?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED कोई भी सहायता राशि
1.	SCCH	

DECLARATION by APPLICANT: (आवेदक द्वारा घोषणा पत्र)

- 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 liable for rejection/cancellation.
- 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.
- 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.
- मैं यहाँ घोषणा करता हूँ कि इस प्रारूप में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य नहीं प्रमाणित पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- मैं इस बात को गंभीरता से "बोडिका फाउन्डेशन", के प्रति सत्य मान रहा हूँ, जिसका उपयोग इसी उद्देश्य की पूर्ति के लिये किया जाएगा, जो इस प्रारूप में कहा गया है।
- मैं यहाँ घोषणा करता हूँ कि मैं इस सहायता हेतु यह प्रयोजन नहीं करूँगा, उस उद्देश्य का अतिक्रमण या समान विवरण किसी अन्य प्रोविडर/एम्प्लॉयर/इंश्योरेंस कंपनी से न ले सकूँगा और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (आवेदक द्वारा स्वीकार)

- 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-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 fulfillment of the "purpose" for which assistance is being requested.
- 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.
- इस रूप में मेरी हस्ताक्षर या मुद्रा के साथ स्वीकार, मैं (आवेदक) अपनी छाप/मुद्रा को यहाँ घोषणा करता हूँ एवं "बोडिका फाउन्डेशन और इसके ट्रस्टियों" को अधिकृत करता हूँ कि मेरा नाम, पता, फोटो और मेरे विवरण इस रूप में प्रकाशित हों, इसे "बोडिका" द्वारा प्रकाशित, प्रिंट, इलेक्ट्रॉनिक द्वारा उद्देश्य के लिये प्रचारित/प्रसारित करने के लिये किया जा सके। इस प्रकार मेरे नाम, पता, फोटो और मेरे विवरण को इस रूप में प्रकाशित करने से मेरी सहायता के लिए कोई भी अधिकार नहीं होगा।
- मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण जो कि सहायता के उद्देश्य से प्रकाशित हों, इस प्रकार: सहायता का स्वीकार नहीं करता। इस संबंध में "बोडिका" द्वारा किये गये निर्णय अंतिम और स्वीकार्य होंगे।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

आवेदक की हस्ताक्षर या बाएँ हाथ की छाप

सुखरानी

AGREEMENT by HOSPITAL (हस्पताल द्वारा स्वीकार)

- 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:
- 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.
 - 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.
- इससे अधिकृत, हस्ताक्षर की जाये कि हमारे/हमारे को "बोडिका फाउन्डेशन" से वित्तीय सहायता हेतु सिफारिश की जाती है, जिसे हम (हस्पताल) वित्त प्रस्ताव से मान्य व स्वीकार करते हैं।
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RECOMMENDED FOR ACCEPTANCE

स्वीकृति के लिए संस्तुति
Dr. Ashwini Kumar
MBBS MS FICO
Reg. No. 66028
Time: _____

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

Date of Surgery
ऑपरेशन की तारीख

12/12/08

(Name of Dr. & Regn. No. Stamp)
डॉक्टर का नाम व हस्ताक्षर व रजि. नं.

FOR INTERNAL USE of KOSHIKA FOUNDATION (आन्तरिक उपयोग हेतु)

SIGNATURE of TRUSTEE 1
(नाम हस्ताक्षर 1)

Sufan

SIGNATURE of TRUSTEE 2
(नाम हस्ताक्षर 2)

Sufan