APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika foundation — Building block of life

APPLICATION No. : आवेदन संख्या :	K11218/1992
APPLICATION DATE : आवेदन तिथि	13/12/18.
NAME of APPLICANT : आवेदक का नाम	MANGAL MALI
AGE-YEARS आयु-वर्ष	68
SEX लिंग	M.
FATHER'S/SPOUSE'S NAME : पिता/पति का नाम	ANANTA MALI

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

BARGA, UTTAR PARA, DHITURDAHA, MINAKHAN, NORTH 24 PARGANAS, WEST BENGAL.

PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता

AS ABOVE.

OCCUPATION : व्यवसाय	UNEMPLOYED.
MARRIED (विवाहित) / UNMARRIED (अविवाहित)	✓ MARRIED
TOTAL ANNUAL INCOME : कुल वार्षिक आय	NIL (Attach Proof of Income) (आय का सबूत संलग्न)
PAN No. स्थाई खाता संख्या	
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता है (जो मान्य हो उस पर सही का निशान लगायें)	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.	MANGAL MALI	68	M	SELF
2.	PRAMILA MALI	55	F	WIFE.
3.	MANISH MALI	31	M	SON
4.	MANIK MALI	28	M	SON

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

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोक्ता कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई सबूत

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

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
1.	DIAGNOSIS – CATARACT – LE.
2.	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

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 assistance, if any, 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 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) [illegible]
2) [illegible]
3) [illegible]

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) [illegible]
2) [illegible]

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

AGREEMENT by HOSPITAL (अस्पताल 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]
1) [illegible]
2. [illegible]

RECOMMENDED FOR ACCEPTENCE
स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख		
13/12/18	Dr. A. Kundu MBBS, MS (Name of Dr. & Regn. No. with Stamp)	Shib Sankar Bagchi (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) Susrut Eye F...

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2
[signature]	[signature]

28.04.2018