

APPLICATION FORM FOR ASSISTANCE (Healthcare)				(Healthcare) (स्वास्थ्य देखभाल)		 Koshika foundation Building block of life	
APPLICATION No.: आवेदन संख्या :		K/0119/2022		APPLICATION DATE: आवेदन तिथि		15-01-2019	
NAME of APPLICANT: आवेदक का नाम		BARASWATI ROUTH		AGE-YEARS वय-वर्ष	59	SEX लिंग	F
FATHER/SPOUSE'S NAME: पिता/सहोदर का नाम				SUDARSHAN DAS			
PRESENT RESIDENCE ADDRESS: वर्तमान निवास स्थान							
54/H/14 KARVEL DARGA MAIN ROAD, KANYKULGARH KOLKATA 700054, WEST BENGAL							
PERMANENT RESIDENCE ADDRESS: स्थायी निवास स्थान							
— AS ABOVE —							
OCCUPATION: व्यवसाय				HOME MAKER			
TOTAL ANNUAL INCOME: कुल वार्षिक आय				NIL			
				MARRIED (विवाहित) / UNMARRIED (अविवाहित)			
				(Attach Proof of Income) (आय का साक्ष्य संलग्न)			
PAN No. (यदि प्राप्त हो):							
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (जो मान्य हो उसे 'X' चिह्नित करें।)							
Yes / No हां / 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 संबंध			
1.	SARASWATI ROUTH	59	F	SELF			
2.	SANJAY ROUTH	26	M	SON			
3.	ASHOK ROUTH	23	M	SON			
4.	ADIPALI ROUTH	29	F	DAUGHTER			
5.	TRIPATI ROUTH	22	F	DAUGHTER			
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिये विधि आधार							
BPL Card (Attach Card Copy) गरीबी रेशा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रती संलग्न करें)		EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रती संलग्न करें)		Ration Card (Attach Copy) उपभोक्ता कार्ड (प्रमाण पत्र की छाया प्रती संलग्न करें)		Any Other Basis/Proof अन्य कोई साक्ष्य	
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किसे मने निम्न का उद्देश्य:							
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached आपका/आपकी से जारी की गई प्रतिवेदन सूची संलग्न						
1.	DIAGNOSIS - CATARACT - RE						
2.	SURGERY - RE (SICS + IOL)						
ASSISTANCE BEING AWAIED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिये गए है?							
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम			AMOUNT of ASSISTANCE BEING AWAIED तो वह सहायता कितनी			

DECLARATION by APPLICANT: अर्थोद्वेग प्रमाण 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) मैं घोषणा करता हूँ कि इस प्रश्न में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य कथन अथवा सत्य बात है तो मेरी प्रार्थना निराश भी न हो सकती है।
- 2) मैं प्रत्यक्ष में प्रार्थना दलित "कोशिका फाउन्डेशन", से ही न्य प्राप्त करूँगा, उसका उपयोग उक्त उद्देश्य की पूर्ति के लिये किया जाएगा, जो इस प्रश्न में वर्णन प्राप्त है।
- 3) मैं यही घोषणा करता हूँ कि मैं इस प्रार्थना हेतु न्य प्राप्त करने की पूर्ति है, उस दलित या व्यक्ति या संस्था द्वारा किसी अन्य सोर्स/एम्प्लॉयर/इन्सुरेंस कंपनी से न तो लिया है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (attach this with)

- 1) 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/republish 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.
- 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 :

अधिकारों के अन्तर्गत वे अधिकारों का विवरण



AGREEMENT by HOSPITAL (बिना डॉक्टर के)

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:

- 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.

RECOMMENDED FOR ACCEPTENCE

सगीकुली ओ दिपू संस्तुति

Date of Surgery अस्त्रोपचार की तारीख 05-01-2019	Dr. Hari Shankar Nag MBBS, MS, (OPHTH) (Name, Designation & Reg. No. with Stamp) हरीशंकर नाग, एमबीबीएस, एमएस, (ऑफ्थैल्मिक)	Anil Sankar Bagchi Director (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) अनिल संकर बगची, निदेशक
---	---	--

FOR INTERNAL USE of KOSHIKA FOUNDATION अन्तर्गत उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यायी इन्द्रका 1	SIGNATURE of TRUSTEE 2 न्यायी इन्द्रका 2
	