

APPLICATION FORM FOR ASSISTANCE
(Healthcare)
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)



APPLICATION No.: K/1119/1974 APPLICATION DATE: 5/11/2019
आवेदन संख्या: आवेदन तिथि

NAME of APPLICANT: PUSPALATA MONDAL AGE-YEARS: 65 SEX: F
आवेदक का नाम

FATHER'S/SPOUSE'S NAME: SAHADEB MONDAL
पिता/पति का नाम

PRESENT RESIDENCE ADDRESS: SERHERDANGA, MURSHIDABAD 742163, WEST BENGAL
वर्तमान आवासीय पता

PERMANENT RESIDENCE ADDRESS: AS ABOVE
स्थायी आवासीय पता



OCCUPATION: COOK MARRIED (निश्चित) / UNMARRIED (अनिश्चित)

TOTAL ANNUAL INCOME: RS 1700 X 12 = 20400/- (Attach Proof of Income)
कुल वार्षिक आय (आय का प्रमाण प्रस्तुत करें)

PAN No. यदि छात्र संकेत

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): Yes / No
क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का निशान लगाएं) हाँ / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) वय (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ सम्बन्ध
1.	PUSPALATA MONDAL	65	F	SELF
2.	ABHISHEK MONDAL	20	M	SON

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

BPL Card (Attach Card Copy) गरीबी रक्षा के पीछे प्रमाण पत्र (प्रमाण पत्र की छात्र प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छात्र प्रति संलग्न करें)	Ration Card (Attach Copy) व्ययवस्था कार्ड (प्रमाण पत्र की छात्र प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई प्रमाण
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु किये गये विधि 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 — LECISICS + IOL

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

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED इस हेतु सहायता की राशि

DECLARATION by APPLICANT: **सावेदक हउ अवेला वः**

- 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 यहाँ पर कदा है कि इस प्रमाण 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 सकती है।
- 2) मेरी दृढ़ वकालत है कि "कोशिका फाउण्डेशन", से ली जा रही है, उसका उपयोग उन्ही उद्देश्य को पूर्ण करने के लिए किया जाएगा, जो इस प्रमाण में मांग गया है।
- 3) मैं यहाँ पर कदा है कि मैंने सहायता हेतु यह प्रमाण नहीं है, इस उद्देश्य का अधिकतम प्रभावित किसी अन्य स्रोत/निर्देशक/बीमा कम्पनी से न ले लिया है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (အပေးသူ ပူးတွဲ ဖော်ပြ)

- 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 :

आलेखक को इच्छा है कि अंग्रेजी का निराकरण

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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.

RECOMMENDED FOR ACCEPTENCE

कृषीकृती के लिए संस्थापि

Date of Surgery
ऑपरेशन की तारीख

ऑपरेटिंग कॉस्ट

5/14/2019

(Name of Dr. & Regn. No. with Stamp)

आमर का नाम य इत्यादि य एति य

(Name, Designation & Stamp of Authorised Signatory
on behalf of Hospital)

નમ્ર ચ જદ હસમતાલ અધિમ્લ અધિકારી

FOR INTERNAL USE of KOSHIKA FOUNDATION

आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1

न्यासी हरदास १

SIGNATURE of TRUSTEE 2

पृष्ठी संख्या 2

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