APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य चिकित्सा)

Koshika
foundation
Building blocks of life

APPLICATION No. आवेदन संख्या	K/0325/2047	APPLICATION DATE आवेदन तिथि	01/03/25
NAME of APPLICANT आवेदक का नाम	PARVEEN BEGUM	AGE-YEARS आयु वर्ष 61	SEX लिंग F
FATHER'S/SPOUSE'S NAME पिता/पति का नाम	AKHTAR HUSSAIN		

PRESENT RESIDENCE ADDRESS : वर्तमान आवासीय पता

9/B, TOPSIA, 2ND LANE, TILJALA,
SOUTH 24 PARAGANAS, 700039, WEST BENGA

PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता

AS ABOVE

OCCUPATION व्यवसाय	HOUSE WIFE	[✓ MARRIED (विवाहित)] / UNMARRIED (अविवाहित)
TOTAL ANNUAL INCOME कुल वार्षिक आय	3000 X 12 = 36,000/-	(Attach Proof of Income) (आय का साक्ष्य संलग्न)
PAN No. स्थाई खाता संख्या		
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable) क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का निशान लगायें)		Yes / [✓ No] हाँ / नहीं

FAMILY DETAILS पारिवारिक 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.	PARVEEN BEGUM	61	F	SELF
2.	AKHTAR HUSSAIN	65	M	HUSBAND
3.	SAHIN BEGUM	40	F	DAUGHTER
4.	TAREK HUSSAIN	35	M	SON

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

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) [illegible] (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशन कार्ड [illegible]	Any Other Basis/Proof अन्य कोई साक्ष्य

"PURPOSE" for REQUESTING ASSISTANCE
सहायता हेतु [illegible]

Sr No. क्रम संख्या	Medical Reports/Prescriptions Attached [illegible]
①	DIAGNOSIS - CATARACT - RE
②	SURGERY - RE (SICS + IOL)

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

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

DECLARATION by APPLICANT [illegible]

1) I hereby confirm that all details in this Form are true to the best of my knowledge [illegible] 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 the assistance is requested.

1) [illegible]

2) [illegible] "कोशिका फाउन्डेशन" [illegible]

3) [illegible]

AGREEMENT by APPLICANT [illegible]

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 in this regard will be final and [illegible].

1) [illegible] "कोशिका" [illegible]

2) [illegible] "कोशिका" [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION :
[illegible]

AGREEMENT by HOSPITAL [illegible]

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 affirmation 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 [illegible] 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 this matter.

[illegible] "कोशिका फाउन्डेशन" [illegible]

1) [illegible] "कोशिका फाउन्डेशन" [illegible] "कोशिका फाउन्डेशन" [illegible]

2) "कोशिका फाउन्डेशन" [illegible] "कोशिका फाउन्डेशन" [illegible] "कोशिका" [illegible]

RECOMMENDED FOR ACCEPTENCE
स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख 01/03/25	Dr.Shibashis Das M.B.B.S M.S Gold Medalist Reg no. 71035 (Name of Dr. & Sign. (with Stamp) [illegible]	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible] अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

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