APPLICATION FORM FOR ASSISTANCE (Healthcare)
सहायता हेतु आवेदन प्रारूप (स्वास्थ्य सहायता)

Koshika foundation
Building block of life

APPLICATION No. / आवेदन संख्या: K/0325/2049

APPLICATION DATE / आवेदन तिथि: 01/03/25

NAME of APPLICANT / आवेदक का नाम: HAMIDA BEGUM

AGE YEARS / आयु वर्ष: 65

SEX / लिंग: F

FATHER'S/SPOUSE'S NAME / पिता/पति का नाम: SAYEED AHMED

PRESENT RESIDENCE ADDRESS / वर्तमान आवासीय पता:
5H/9, BIBI BAGAN LANE, KOLKATA,
MUNICIPAL CORPORATION, TANGRA, 700015,

PERMANENT RESIDENCE ADDRESS / स्थाई आवासीय पता:
AS ABOVE

OCCUPATION / व्यवसाय: MAID

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME / कुल वार्षिक आय: 3500 X 12 = 42,000/-

(Attach Proof of Income)

PAN No. / स्थाई खाता संख्या:

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): YES / [✓ NO]

FAMILY DETAILS / परिवार विवरण

Sr. No. / क्रम संख्या	Name of Family Member / परिवार के सदस्यों का नाम	Age (Years) / आयु (वर्ष)	Gender / लिंग	Relation with Applicant / आवेदक के साथ सम्बन्ध
1.	HAMIDA BEGUM	65	F	SELF
2.	SAKIL AHMED	40	M	SON
3.	SAMIM AHMED	38	M	SON
4.	SARFARAZ AHMED	35	M	SON
5	SAKILA BEGUM	32	F	DAUGHTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिये निम्नलिखित 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) राशनकार्ड [illegible]	Any Other Basis/Proof [illegible]

"PURPOSE" for REQUESTING ASSISTANCE

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

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

Sr. No. / क्रम संख्या	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED

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 [illegible] will [illegible] 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 the assistance is requested.

1. मैं घोषणा करता हूँ कि इस प्रपत्र [illegible]
2. [illegible] "कोशिका फाउन्डेशन" [illegible]
3. मैं पुष्टि करता हूँ कि [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 [illegible]/publish/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/requirements. 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 [illegible] of my name, address, photo & details [illegible] for which such assistance is requested/granted will not automatically entitle me for receiving or continuing the said assistance. The decision [illegible] concerning 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]

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 [illegible] 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 [illegible] 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 [illegible] NGO or any other source. This [illegible] essentially states that the Hospital will not avail any duplicate assistance for the same [illegible] NGO or any other source.
2. The assistance from Koshika Foundation is only financial in nature. The choice of the [illegible] conducted by the Hospital on the patient, is based on the arrangement between the patient & the Hospital, and is in no way [illegible] 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] "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 MS Gold Medalist Reg no: 71036 (Name of [illegible] with Stamp)	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]

FOR INTERNAL USE of KOSHIKA FOUNDATION (आंतरिक उपयोग हेतु)

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

10.03.2022