

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य सहायता)



Building block of life

APPLICATION No. / आवेदन संख्या: **W/0325/2050**

APPLICATION DATE / आवेदन तिथि: **01/03/25**

NAME of APPLICANT / आवेदक का नाम: **JAITUNNISHA**

AGE YEARS / आयु वर्ष: **79**

SEX / लिंग: **F**

FATHER'S/SPOUSE'S NAME / पिता/ससुरा का नाम: **MD AKBAR**

PRESENT RESIDENCE ADDRESS / वर्तमान निवासी पता: **29/H/33, LINTON STREET, ENTALLY KOLKATA, 700014, WEST BENGAL**

PERMANENT RESIDENCE ADDRESS / स्थायी निवासी पता: **AS ABOVE**



OCCUPATION / व्यवसाय: **HOUSEWIFE**

MARRIED (विवाहित) / UNMARRIED (अविवाहित): **MARRIED**

TOTAL ANNUAL INCOME / कुल वार्षिक आय: **35000 x 12 = 42,000/-**

(Attach Proof of Income) / आय का प्रमाण प्रस्तुत करें

PAN No. / आयकर पहचान संख्या

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): **Yes / हाँ**

Sl. No. / क्रम संख्या	Name of Family Member / परिवार के सदस्य का नाम	Age (Years) / आयु (वर्ष)	Gender / लिंग	Relation with Applicant / आवेदक से संबंध
1.	JAITUNNISHA	79	F	SELF
2.	MD NAUSHAD	49	M	SON
3.	SAMSUNNISHA	47	F	DAUGHTER
4.	NABUJA KHATUN	45	F	DAUGHTER
5.	TAYRA KHATUN	43	F	DAUGHTER
6.	KAJDA KHATUN	40	F	DAUGHTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy)	Ration Card (Attach Copy)	Any Other Basis/Proof
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"PURPOSE" for REQUESTING ASSISTANCE

Sl. No. / क्रम संख्या	Medical Reports/Prescriptions Attached (आवश्यक दवाइयां से संबंधित डॉक्टरों की लिखित राय प्रस्तुत करें)
①	DIAGNOSIS - CATARACT - LE
②	SURGERY - LE (SICS + IOL)

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

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

