

APPLICATION FORM FOR ASSISTANCE
सहायता देत् अवैदन प्रारूप

(Healthcare)
(स्वास्थ्य चेत्तमाल)

APPLICATION No.: K/0524/0141
ग्राहन संख्या :

APPLICATION DATE : 05/05/24

NAME of APPLICANT: SAMAR MODAK

AGE-YEARS 30-31 SEX M

FATHER'S/SPOUSE'S NAME : DULAL CHANDRA MODAK
পিতৃ/স্বামীর নাম মোদক

PRESENT RESIDENCE ADDRESS: वर्तमान बस्ती का
34, GOURANGA DHAM - GOURANGA GHAT ROAD,
NEAR ISCON TEMPLE, PANIHAITI, NORTH 24
PARGINAS 700114, WEST BENGAL

THE JOURNAL OF CLIMATE

~~MS. ABBEY —~~

OCCUPATION:

UNEMPLOYED

MARRIED (प्रधित) / UNMARRIED (अप्रधित)

TOTAL ANNUAL INCOME:

$$5000 \times 12 = 60,000$$

(Kash. Proof of income)

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ARE YOU AN INCOME TAX ASSISSEE? (Check whichever is applicable)

Year 1/200
Ref. 4-200

FAMILY DETAILS

FAMILY DETAILS परिवार विवरण				
Sl. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) वय (वर्ष)	Gender लिंग	Relation with Applicant अप्लाईट के साथ सम्बन्ध
1.	SAMAR MODAK	70	M	SELF
2.	KINA MODAK	34	F	WIFE
3.	KUDIP MODAK	30	M	SON
4.	PRADIP MODAK	30	M	SON

BASIS for REQUESTING ASSISTANCE (Indicate whichever is applicable)
समाज को दिले रखनी चाहिए

BPL Card
(Attach Card Copy)

**EWS Certificate
(Attach Certificate Copy)**

Ration Card
(Attached Copy)
राशन कार्ड

Any Other
BusinessPoint
जन्म वर्तमान समय

"PURPOSE" for REQUESTING ASSISTANCE:
मानव सेवा के लिए यह सहायता की ज़रूरत है।

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached सम्बन्धित रिपोर्ट वा नियन्त्रण की गई दस्तावेज़ सूची सहित
1.	DIAGNOSIS — CATARACT — RE
2.	SURGERY — RE (STICS + IOL)

ASSISTANCE BEING AWARDED for SAME "PURPOSE" from OTHER SOURCES

DECLARATION by APPLICANT: I declare that these are true.

- 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.
 - I solemnly confirm that assistance, if received from Koshika Foundation, will be used only for the "purposes", as stated in this Form, for which such assistance was requested by me.
 - 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 पांच वर्षों से कि इस अवधि में रिकार्ड यदि वापसी के लकड़ा तार नहीं है, तो उसके लिए इसके दूर बढ़ने वाला चाहा है कि ये भौतिक जिम्मे को क्या बदलते हैं।

2) मैं इस के बाबत की "प्रतिक्रिया प्रक्रिया", में नहीं जुटता हूँ, तबकि अपने यही विवरण को गृहीत के लिए दिया जाएगा, जो इस अवधि में यह था।

3) मैं युविं वाला हूँ कि यह अवधि दूसरे वर्ष तक बढ़ने चाहे तो है, जब तकी का आवश्यक या वापसी के लिए दिया जाना चाहिए तो ये वर्ष वापसी के लिए

AGREEMENT by APPLICANT (initials or name)

APPLICANT'S SIGNATURE OR I FEE THIS INFORMATION.

संस्कृत एवं राष्ट्रीय विद्यालय

January 19, 1948

AGREEMENT by HOSPITAL (Signature required)

By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Kochiha Foundation (Hospital) hereby affirm & agree as follows:

- (Principal) 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 involvement in the matter.

३. “कोलिका वर्षान्देशन” तो सबै यसका बोला चिह्नित भएको छोटो चो हो। ऐसी प्रथमकाल हाल यी यस काल या जिन्हें यसे उपचारप्रक्रिया का भुगाए गेहोरी थाँउ इमानदार
यो विधि हो जो “कोलिका वर्षान्देशन” हाल जिसी बाटाका बोर्ड रकम चाही हो। यसकोपरे इमानदार यो ऐसी प्रथम दूसरा और अबैं चाहने बोही चाही जिमोहोरी चोहोरी यस इमानदार
को दोहोरी और “कोलिका” यो दोहोरी भूमिका या जिमोहोरी प्रथा घोषणामा भए हुन् जानेको।

RECOMMENDED FOR ACCEPTANCE
स्वीकृति के लिए संशोधित

Date of Surgery
दृष्टिकोण की तिथि

85/05/20

D.S. Shinde DSC

OPTIONAL FORM NO. 277 DAS
Society Registration Act, 1956

FOR INTERNAL USE of NOKSHKA FOUNDATION

SIGNATURE of TRUSTEE 1

Sympath

SIGNATURE of TRUSTEE 2
नामी व्यक्ति २

Eric B