

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika
foundation
Building Block of life.

APPLICATION No.: 1C/1224/1463

APPLICATION DATE: 19/12/24

NAME of APPLICANT: LAKSHMI SARDAR

AGE-YEARS: 76

SEX: F

FATHER'S/SPOUSE'S NAME: LALDEB SARDAR

PRESENT RESIDENCE ADDRESS: वर्तमान आवास का पता

PETUADHANIPATI, MATIGARI, NORTH 24

PARGANAS 743442, WEST BENGAL

PERMANENT RESIDENCE ADDRESS: स्थायी आवास का पता

— AS ABOVE —

OCCUPATION: HOME MAKER

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: 4000X12 = 48,000/-

(Attach Proof of Income)
(आय का साक्ष्य संलग्न)

PAN No. स्थायी आय का प्रमाण

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable)
क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का निशान लगाएं)

Yes / हाँ / No / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक से संबंध
1.	LAKSHMI SARDAR BEWA	76	F	SELF
2.	LALDEB SARDAR	82	M	NEPHEW

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

BPL Card (Attach Card Copy) गरीबी रेशा के नीचे प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि संलग्न करें)	EMS Certificate (Attach Certificate Copy) आय आय कर प्रमाण पत्र (प्रमाण पत्र की प्रतिलिपि संलग्न करें)	Ration Card (Attach Card Copy) उपभोग्यता कार्ड (प्रमाण पत्र की प्रतिलिपि संलग्न करें)	Any Other Basic/Proof अन्य कोई साक्ष्य
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"PURPOSE" for REQUESTING ASSISTANCE:
सहायता हेतु दिने गये निम्न का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से सही की गई प्रतिवेदन सूची संलग्न
1.	DIAGNOSIS — CATARACT — RE
2.	SURGERY — RE (Cataract + IOL)

ASSISTANCE BEING AWARDED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से मिल चुकी है?

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

DECLARATION by APPLICANT: अवैध दल घोषणा पर:

- 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/termination.
- 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 घोषणा करता हूँ कि इस प्रत्यय में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण एवं फर्म असत्य पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- 2) मैं दृढ़ता से सहायता प्रति "कोशिका फाउंडेशन", से लेती या लेंगे है, उसका उपयोग उसी उद्देश्य के पूर्ति के लिये किया जायेगा, जो इस प्रत्यय में पाया गया है।
- 3) मैं यही प्रमाण देता हूँ कि मैंने सहायता प्राप्त कर लेने के बाद अन्य किसी भी अन्य स्रोत/रोजगार/बिमा कंपनी से वही सहायता नहीं और वही प्रत्यय में घोषणा

AGREEMENT by APPLICANT (अर्शक हाण मयार)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize 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 fulfillment 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 is this regard will be final and acceptable to me.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

आवेक में समझना या मांगें का दिखाना



AGREEMENT by HOSPITAL (64508 100 000)

By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Kashiha 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 ACCEPTANCE

सभीकु्यों के लिए संसाधन

Date of Surgery

ऑपरेशन की जाँच

12 | 24

Dr. Shibashis Das

(Name of Dr. J. Nigam, M.D. with Stamp)

संख्या-२०७३/१९८४ दिनांक २५/०६/८४

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

नाम न पर हस्तकृत अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION ગાંધીક મંથન ફાઉન્ડેશન

वैयक्तिक वित्तियेन सेतु

SIGNATURE of TRUSTEE 1

न्यासी विद्वान् ।

Exchanged

SIGNATURE of TRUSTEE 2

न्यायी इम्तियाज २

here