

DEI-4-14-11-3833

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika
foundation

Building block of life

APPLICATION No.

आवेदन संख्या

E/0525/0050

APPLICATION DATE

आवेदन तिथि

1/5/25

NAME of APPLICANT

आवेदक का नाम

SAIMA PRAVEEN

AGE-YEARS वर्ष-वर्ष

SEX लिंग

08 YEARS

FEMALE

FATHER/SPOUSE'S NAME

पिता/पत्नी का नाम

MOHID WASIM (FATHER)

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

VILLAGE BHARWARA, DARRUNGA, BIHAR-847104

PERMANENT RESIDENCE ADDRESS स्थायी आवासीय पता

OCCUPATION

व्यवसाय

TAILOR (FATHER)

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME

कुल वार्षिक आय

96,000 (FATHER)

(Attach Proof of Income)

(आय का सबूत संलग्न करें)

PAN No. पैन आई नम्बर

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable)

क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का चिह्न लगाएं)

Yes / No

हां / 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.	MOHID WASIM	40	MALE	FATHER
2.	SAIMA PRAVEEN	39	FEMALE	MOTHER
3.	SAHIL	16	MALE	BROTHER
4.	MASEEM	16	MALE	BROTHER
5.	SAIBA	14	FEMALE	SISTER
6.	AMIR	14	FEMALE	SISTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता को लिए विनियम आधार

EPI Card (Attach Card Copy) ग्रामीण सेवा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) जन्य आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोग्य कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई सबूत
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"PURPOSE" for REQUESTING ASSISTANCE

सहायता हेतु किसे सबे विनियम का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन दृष्टि संलग्न
1.	DIAGNOSIS - RETINOBLASTOMA
2.	TREATMENT - EVA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से ली जा रही है?

NO

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED कोई भी सहायता राशी
	NA	

DECLARATION by APPLICANT (आवेदक द्वारा भरण):

- 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 liable for reprobation/cancellation.
- 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.
- 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.
- मैं यहाँ कह रहा हूँ कि इस प्रकार के सब सब सही विवरण को जानकारी के अनुसार सब सही है। यदि कोई झूठा दावा किया गया होगा तो इस पर सवाल खड़ा हो जायेगा।
- मैं यहाँ जो मागना रहा "कोशिका फाउंडेशन", से जो मैं को है, उसका उपयोग इसी उद्देश्य को पूर्ण के लिए किया जाएगा, जो इस प्रकार में माग रहा है।
- मैं यहाँ कह रहा हूँ कि मैं इस प्रकार से ही मदद को नहीं ले, उस मदद का अधिकार या कबल किसी अन्य सोर्स/एम्प्लॉयर/इंश्योरन्स कंपनी से न हो सके है और न ही कोशिका के द्वारा।

AGREEMENT by APPLICANT (आवेदक द्वारा कर):

- By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and it's Trustees to use/publish/post-upreproduce 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.
- 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 acceptable to me.
- इस प्रकार पर आवेदक द्वारा या अपने डॉक्टर को कर लक्षण, मैं (आवेदक) अपनी सहर्षी को मुद्रा अंकन हूँ एवं "कोशिका फाउंडेशन और ट्रस्टी" को अधिकृत करता हूँ कि वे मेरा नाम, पता, फोटो और जो विवरण इस प्रकार में माग रहा है, उसे "कोशिका" एम्प्लॉयर, डॉ. अचरज गुप्ता उद्देश्य से मुद्रा प्रसारित करें और जानकारी के लिए किसी भी प्रकार माग से प्रतिक्रिया करने के लिए अधिकृत है। मैं इसका विवरण भी इसका जो पता मैं करने के लिए "कोशिका फाउंडेशन" व अपनी अधिकृत है।
- मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण को मैं मागवा के उपयोग में प्रयोग है मुझे सहा, सहायता का इच्छा नहीं करता। इस संबंध में "कोशिका" एम्प्लॉयर ट्रस्टी का निर्णय अंतिम और बाध्यकारी होगा।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

आवेदक के हस्ताक्षर या बायाँ हाथ का निशान

आवेदक का हस्ताक्षर

AGREEMENT by HOSPITAL (हॉस्पिटल द्वारा कर):

- By affixing hereunder, signature of our Authorized Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we (Hospital) hereby affirm & accept following:
- 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.
 - 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.

हमारे अधिकृत हस्ताक्षर को जो मैं यहाँ पर मागवा रहा है "कोशिका फाउंडेशन" को जिला सहायक हेतु सिफारिश को जारी है, जिसे हम (हॉस्पिटल) इस प्रकार से मान्यता दे रहे हैं।

- 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.
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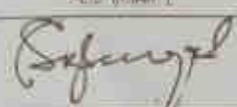
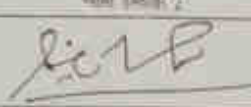
RECOMMENDED FOR ACCEPTANCE

स्वीकृति के लिए अनुमति

Date of Surgery ऑपरेशन की तारीख 4/5/25	 Dr. CHIRAVI GUPTA (Name of Dr. & Hospital Name with Stamp) Jyoti's Charity Eye Hospital & Ophthalmic Services Plot No. 107/25 Sector 10, Gurgaon	 (Name, Designation & Stamp of Authorized Signatory) Jyoti's Charity Eye Hospital & Ophthalmic Services Plot No. 107/25 Sector 10, Gurgaon
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FOR INTERNAL USE OF KOSHIKA FOUNDATION

आवेदक द्वारा हेतु
Dr. Sankar's Charity Eye Hospital

SIGNATURE of TRUSTEE 1 ज्योती हॉस्पिटल 1 	SIGNATURE of TRUSTEE 2 ज्योती हॉस्पिटल 2 
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Dr. Shroff's Charity Eye Hospital

Caring for the community since 1914...



Dr. Shroff's Charity Eye Hospital
Delhi is NABH Accredited

31st May 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby. Saima Parveen- E/0525/0050

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital <u>Retinoblastoma Surgeries</u>					
Name		Baby: Saima Parveen	Address/ Phone:	Village Bhanwara, Darbhanga Bihar-847104	
MR N		DEL-G-19-11-3833	Age/Sex	6 years	Female
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	30/05/2025	Examination under anesthesia	2000	1	2000
		Total			2000

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL

5027, Kedar Nath Road Daryaganj, New Delhi-110002 India

Ph:- 011-4352 4444, 4352 8888, Fax : 011-43528816

E-mail : sceh@sceh.net, Website : www.sceh.net

OTHER CENTRES

ALWAR • SAHARANPUR • MEERUT • LAKHIMPUR KHERI • VRINDAVAN • KAROL BAGH (DELHI)