DEL-G-23-01-3062

APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रपत्र

Koshika Foundation

APPLICATION No.	E 0625 0104	APPLICATION DATE	28/6/25
NAME of APPLICANT	SHIVANSHU	AGE YEARS: 3 YEARS	SEX: MALE
FATHER'S/SPOUSE'S NAME	SUSHIL RAJAK (FATHER)		

PRESENT RESIDENCE ADDRESS

MAKAN NUMBER - 216, GRAM KARODI BAHIRUA, JABALPUR, MADHYA PRADESH - 4832[illegible]

PERMANENT RESIDENCE ADDRESS

OCCUPATION	LABOURER (FATHER)	MARRIED / UNMARRIED	
TOTAL ANNUAL INCOME	96,000 (FATHER)	(Attach Proof of Income)	
PAN No.			
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable)		Yes / No	

FAMILY DETAILS

Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
1	SUSHIL RAJAK	34	MALE	FATHER
2	PRIYA	32	FEMALE	MOTHER
3	RIYA	11	FEMALE	SISTER
4	SWATI	9	FEMALE	SISTER
5	NIHARIKA	2	FEMALE	SISTER
6	SIDYA	1	FEMALE	SISTER

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

"PURPOSE" for REQUESTING ASSISTANCE

Sr. No.	Medical Reports/Prescriptions Attached
1	DIAGNOSIS - RETINOBLASTOMA
2	TREATMENT - EUA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES: NO

Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED
	NA	

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 statement will render 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 this assistance is requested.

1) मैं घोषणा करता हूँ कि इस प्रपत्र में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही है। [illegible]
2) [illegible] "कोशिका फाउंडेशन" [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 use/publish/out-use/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 fulfilment 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 in this regard will be final and acceptable to me.

1) [illegible] "कोशिका फाउंडेशन और उसके न्यासीयों" [illegible]
2) मैं (आवेदक) [illegible] "कोशिका फाउंडेशन" [illegible]
"कोशिका" [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION
आवेदक का हस्ताक्षर या अंगूठे का निशान

उशीत

AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial 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 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.

[illegible] "कोशिका फाउंडेशन" [illegible]
1) [illegible]
[illegible]
2. "कोशिका फाउंडेशन" [illegible]
[illegible]

RECOMMENDED FOR ACCEPTENCE
स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख	(Name of Dr. & Regn. No. with Stamp)	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital)
30/06/25	Dr. CHHAVI GUPTA	Dr. [illegible]

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

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

30-11-2024

Dr. Shroff's Charity Eye Hospital
Caring for the community since 1922...

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

30th June 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Shivanshu- E/0625/0104

Estimate cost of treatment
Dr. Shroff's Charity Eye Hospital
Retinoblastoma Surgeries

Name		Shivanshu	Address/ Phone:	Makan number-216, Gram Madai Pahirua, Jabalpur, Madhya pradesh-483225	
MR N		DEL-G-23-01-3062	Age/Sex	3 years	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	2025-06-30	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
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