BLC4 24 11 - 4064

APPLICATION FORM FOR ASSISTANCE (Healthcare)
सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika Foundation

APPLICATION No आवेदन संख्या	E/0925/0185
APPLICATION DATE आवेदन तिथि	2/9/25
NAME of APPLICANT आवेदक का नाम	KUNAL JAISWAL
AGE-YEARS आयु-वर्ष	9 YEARS
SEX लिंग	MALE
FATHER/SPOUSE'S NAME पिता/पति का नाम	VIJAY JAISWAL (FATHER)

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

DEERI, VAISHALI, BIHAR - 844504

PERMANENT RESIDENCE ADDRESS स्थाई आवासीय पता

OCCUPATION व्यवसाय	LABOURER (FATHER)
MARRIED (विवाहित) / UNMARRIED (अविवाहित)	
TOTAL ANNUAL INCOME कुल वार्षिक आय	1,08,000 (FATHER) (Attach Proof of Income / आय का साक्ष्य संलग्न)
PAN No स्थाई खाता संख्या	
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable) क्या आप आय कर दाता है (जो लागू हो उस पर सही का निशान लगाएं)	Yes / No हां / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्रम संख्या	Name of Family Member परिवार के सदस्य का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ संबंध
1	VIJAY	36	MALE	FATHER
2	RAHMA	33	FEMALE	MOTHER
3	SHREYA	17	FEMALE	SISTER
4	MUSKAN	15	FEMALE	SISTER
5	KRISH	13	MALE	BROTHER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)
सहायता के लिए निर्णय आधार

BPL Card (Attach Card Copy) गरीबी रेखा से नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आर्थिक आधार कमजोर प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	Any Other Basis/Proof अन्य कोई साक्ष्य

"PURPOSE" for REQUESTING ASSISTANCE
सहायता हेतु किये गये निवेदन का उद्देश्य:

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

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES NA
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया हो?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
	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) [illegible]
2) [illegible]
3) [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/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 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]
2) [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION
[illegible]

Vijay kumar

AGREEMENT by HOSPITAL (अस्पताल द्वारा करार)

By affixing hereunder, signature of our Authorised Signatory for recommending the 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 it 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]
1) [illegible]
2) [illegible]

Dr. SIMA DAS
Director
Oculoplasty and Ocular oncology services
Director, Medical Education Department
Regd. No. 00291
Dr. Shroff's Charity Eye Hospital

RECOMMENDED FOR ACCEPTENCE स्वीकृति के लिए संस्तुति		
Date of Surgery ऑपरेशन की तारीख 4/9/25	Dr. CHHA GUPTA Adjunct Consultant Oculoplasty and Ocular Oncology Services Regd. No. 100745 Dr. Shroff's Charity Eye Hospital (Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. न.	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]

FOR INTERNAL USE of KOSHIKA FOUNDATION आंतरिक उपयोग हेतु	
SIGNATURE of TRUSTEE 1 ट्रस्टी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 ट्रस्टी हस्ताक्षर 2
[signature]	[signature]

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

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

30th September,2025

Dear Mr Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Kunal jaiswal- E/0925/0185

Estimate cost of treatment Dr. Shroff's Charity Eye Hospital *Retinoblastoma Surgeries*					
Name		Kunal jaiswal	Address/ Phone:	Deeri,Vaishali,Bihar-844504	
MR N		DEL-G-24-11-4064	Age/Sex	9 years	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	04/09/2025	Examination under Anesthesia(EUA)	2000	1	2000
		Total			2000

Best Regards

Dr. Sima Das

Director, Oculoplasty and Ocular Oncology Services

Dr. SIMA DAS
Director
Oculoplasty and Ocular oncology services
Director Medical Education Department
Dr. Shroff's Charity Eye Hospital

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