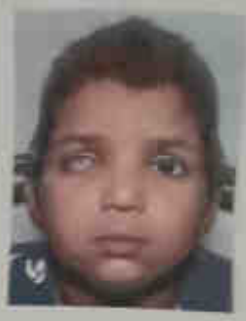
DEL-G-24-03-5504

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

Koshika foundation
Building vision of life

APPLICATION No. आवेदन संख्या	E 0925 0207	APPLICATION DATE आवेदन तिथि	24/9/25



NAME of APPLICANT आवेदक का नाम	MD. HASAN	AGE-YEARS आयु-वर्ष	SEX लिंग
		04 YEARS	MALE

FATHER'S/SPOUSE'S NAME पिता/पति का नाम: ALI MOHD (FATHER)

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता: GULRA TANDA, BILA, KHERI, U.P.-262545

PERMANENT RESIDENCE ADDRESS स्थाई आवासीय पता:

OCCUPATION व्यवसाय: LABOURER (FATHER) — MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME कुल वार्षिक आय: 1,20,000 (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 मान्य हो उस पर सही का निशान लगाये) 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 के साथ सम्बंध
1.	ALI MOHD	40	MALE	FATHER
2.	JAHIDA	33	FEMALE	MOTHER
3.	SNSRANA	03	FEMALE	SISTER
4.	MD. HUSSAIN	06	MALE	BROTHER

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

BPL Card (Attach Card Copy) गरीबी रेखा का नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) अल्प आय वर्ग 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 विनती का उद्देश्य:

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

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया है। NO

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

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.

[illegible]

[illegible]

[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/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.

[illegible] "कोशिका फाउंडेशन और उसके न्यासीगण" [illegible]

[illegible] "कोशिका" [illegible]

[illegible] "कोशिका फाउंडेशन" [illegible]

2) मैं (आवेदक) [illegible]

"कोशिका" [illegible]

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

RT (mother)

AGREEMENT by HOSPITAL (अस्पताल 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] "कोशिका फाउंडेशन" [illegible]

[illegible] "कोशिका फाउंडेशन" [illegible] "कोशिका फाउंडेशन" [illegible]

[illegible]

[illegible]

2) "कोशिका फाउंडेशन" [illegible]

[illegible] "कोशिका फाउंडेशन" [illegible]

[illegible] "कोशिका" [illegible]

Dr. SIMA DAS

RECOMMENDED FOR ACCEPTENCE स्वीकृति के लिए संस्तुति

Date of Surgery ऑपरेशन की तिथि	Dr. CHHA GUPTA Oculoplasty and Ocular Oncology Services Regd. No. 109745 Dr. Shroff's Charity Eye Hospital (Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. नं.	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्ताक्षर अधिकृत अधिकारी
24/9/26		

FOR INTERNAL USE of KOSHIKA FOUNDATION आंतरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी 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 Mohd Hasan- E/0925/0207

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

Name		Mohd Hasan	**Address/ Phone:**	Gulra tanda, Bela, khen, U.P - 262902	
MR N		DEL-G-24-03-5504	**Age/Sex**	4 years	Male
S. No.	**Treatment date**	**Items**	**Cost per Unit**	**No. of unit**	**Aprox. Cost**
1	24/09/2025	Examination under Anesthesia(EUA)	2000	1	2000
2	24/09/2025	Chemotherapy	2500	1	2500
		Total			**4500**

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

Best Regards

Dr. Sima Das

Director, Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL
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E-mail : sceh@sceh.net, Website : www.sceh.net