DEL-G-24-11-4064

APPLICATION FORM FOR ASSISTANCE (Healthcare)

Koshika foundation

APPLICATION No.	E / 0126 / 0329
APPLICATION DATE	13/01/26
NAME of APPLICANT	KUNAL JAISWAL
AGE-YEARS	08 YEARS
SEX	MALE
FATHER/SPOUSE'S NAME	VIJAY KUMAR (FATHER)
PRESENT RESIDENCE ADDRESS	DESARI, BIHAR - 814508
PERMANENT RESIDENCE ADDRESS	
OCCUPATION	LABOURER (FATHER)
MARRIED / UNMARRIED	
TOTAL ANNUAL INCOME	1,08,000 (FATHER)
(Attach Proof of Income)	
PAN No.	
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable)	Yes / No

FAMILY DETAILS

Sl. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
1	VIJAY JAISWAL	36	MALE	FATHER
2	RADHA CHADDHA	33	FEMALE	MOTHER
3	SAHEYA	12	FEMALE	SISTER
4	MOHAN	15	FEMALE	SISTER
5	KRISH	13	MALE	BROTHER

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

Sl. No.	Medical Reports/Prescriptions Attached
1.	DIAGNOSIS - RETINOBLASTOMA
2.	TREATMENT - EUA, CHEMOTHERAPHY.

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

NO

Sl. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED
	NIL	

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/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 :
आवेदक के हस्ताक्षर या अंगूठे का निशान

Vijay kumar

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]
1) [illegible]
2) [illegible]

	RECOMMENDED FOR ACCEPTENCE स्वीकृति के लिए संस्तुति	
Date of Surgery ऑपरेशन की तिथि 20/01/25	Dr. CHHAVI GUPTA Adjunct Consultant Oculoplasty and Ocular Oncology Services Regd. No. 100749 Dr. Shroff's Charity Eye Hospital (Name of Dr. & Regn. No. with Stamp) [illegible]	Dr. [illegible] Director Oculoplasty And Ocular [illegible] Services Director Medical Education Department Regd. No. 20291 Dr. Shroff's Charity Eye Hospital (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]

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]

18-06-2024

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

Dr. Shroff's Charity Eye Hospital

31st January 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Mast. Kunal Jaiswal- I/012500329

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

Name		Mast. Kunal Jaiswal	Address/ Phone:	Dewari,Bihar - 844504	
MR No		DEL-G-24-11-4084	Age/Sex	4 years	Male
S. No.	Treatment date	Items	Cost per Unit	No. of unit	Approx. Cost
1	2025-01-31	EUA	2000	1	2000
2	2025-01-31	Chemo	2500	1	2500
		Total			4500

Best Regards

Dr. Sima Das

Director

Oculoplasty and Ocular Oncology Services

DR. SHROFF'S CHARITY EYE HOSPITAL
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