DCI-6-24-05-2021

APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika foundation — Building block of life

APPLICATION No. / आवेदन संख्या: E/0225/0381	APPLICATION DATE / आवेदन तिथि: 05-03-25
NAME of APPLICANT / आवेदक का नाम: TEJASVI	AGE-YEARS आयु-वर्ष: 04 YEARS; SEX लिंग: FEMALE
FATHER'S/SPOUSE'S NAME / पिता/पति का नाम: SAYARAM (FATHER)	

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

VILL - HINGWA FOALWADI WARLA BARWANI MADHYA PRADESH - 451551

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 प्रमाण संलग्न)

PAN No. स्थाई खाता संख्या

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable) Yes / No

क्या आप आय कर दाता हैं (जो लागू हो उस पर सही का निशान लगायें) हाँ / 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 संबंध
1.	SAYARAM	35	MALE	FATHER
2.	SARITA	24	FEMALE	MOTHER
3.	PRATIGYA	07	FEMALE	SISTER
4.	KRISHNA	06	FEMALE	SISTER
5.	VYANSHI	08 MONTHS	FEMALE	SISTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिये निर्धारित आधार

BPL Card (Attach Card Copy) गरीबी रेखा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोक्ता कार्ड (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 प्रिस्क्रिप्शन सूची संलग्न
1.	DIAGNOSIS - RETINOBLASTOMA
2.	TREATMENT - EUA, CHEMO, MRI

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES NA

इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिया गया है?

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 [illegible]: Any false statement will render my Application & ongoing assistance [illegible]

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 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 ([illegible])

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 is this regard will be final and acceptable to me.

1) [illegible]

2) [illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:
[illegible]

Sonai

AGREEMENT by HOSPITAL ([illegible])

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
[illegible]

Date of Surgery [illegible]	(Name of Dr. & Regn. No. with Stamp) [illegible]	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]
10/3/25	[illegible] ...VI GUPTA ... Oncology Services	Dr. [illegible] DAS

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

SIGNATURE of TRUSTEE 1 [illegible]	SIGNATURE of TRUSTEE 2 [illegible]
[signature]	[signature]

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

31st March 2025

Dear Mr. Tandon

Greetings from Dr. Shroff's Charity Eye Hospital!

Please find below attached estimate expenditure of Baby. Tejasvi Senani-**E/0325/0381**

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

Name		Baby. Tejasvi Senani	**Address/ Phone:**	Village Hingwa,Barwani,Madhya Pradesh-451551	
MR N		DEL-G-24-05-3221	**Age/Sex**	4 years	Female
S. No.	**Treatment date**	**Items**	**Cost per Unit**	**No. of unit**	**Aprox. Cost**
1	2025-03-10	EUA	2000	1	2000
2	2025-03-10	Chemotherapy	2500	1	2500
3	2025-03-07	MRI	6500	1	6500
		Total			**11000**

Best Regards

Dr. Sima Das

Director

For Dr. Sima Das

Oculoplasty and Ocular Oncology Services

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