MOM-E 25 - 02 - 2626

APPLICATION FORM FOR ASSISTANCE (Healthcare)

सहायता हेतु आवेदन प्रारूप (स्वास्थ्य देखभाल)

Koshika foundation
Building block of life

APPLICATION No. / आवेदन संख्या :	E / 0325 / 0386
APPLICATION DATE / आवेदन तिथि	15-03-25
NAME of APPLICANT / आवेदक का नाम	NAYRA
AGE-YEARS आयु-वर्ष	03 YEARS
SEX लिंग	FEMALE
FATHER'S/SPOUSE'S NAME / पिता/जीवनसाथी का नाम	SAMSUL HASAN (FATHER)

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

RIASPUR, U.P. - 445001.

PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता

OCCUPATION / व्यवसाय	CLOTH VENDOR (FATHER)
MARRIED (विवाहित) / UNMARRIED (अविवाहित)	
TOTAL ANNUAL INCOME / कुल वार्षिक आय	1,08,000 (FATHER)
(Attach Proof of Income) (आय का सबूत 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 लगाएँ)	Yes / No 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.	SAMSUL HASAN	36	MALE	FATHER
2.	RASIYA	26	FEMALE	MOTHER
3.	ANAYA	03	FEMALE	SISTER
4.	SHAHAN	09	MALE	BROTHER
5.	JEVAN	25	MALE	GRANDMOTHER
6.	MEENATI	60	FEMALE	AUNTY.
7.	FARZANA	31	FEMALE	

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

BPL Card (Attach Card Copy) गरीबी रेखा के 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 सबूत

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

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

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]

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 [illegible] 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]

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 in this regard will be final and acceptable to me.

[illegible]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION

[illegible]

~ [signature]

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]

RECOMMENDED FOR ACCEPTENCE

स्वीकृती के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख	(Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व [illegible]	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) द्वारा व पद हस्ताक्षर अधिकृत अधिकारी
17/03/25	[signature] Dr. CHHAVI GUPTA [illegible] Consultant, [illegible] Ocular Oncology Services [illegible] Regd. No. 100745 Dr. Shroff's Charity Eye Hospital	[signature] Dr. SIMA DAS Director Oculoplasty and Ocular oncology services Director, Medical Education Department Dr. [illegible] Hospital

FOR INTERNAL USE IN KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2
[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 Nayra-**E/0325/0386**

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

Name		Nayra	Address/ Phone:	Bilaspur,Uttar Pradesh-495001	
MR N		MOM-E-25-02-2626	Age/Sex	3 years	Female
S. No:	Treatment date	Items	Cost per Unit	No. of unit	Aprox. Cost
1	2025-03-17	Genetic Test	20000	1	20000
		Total			**20000**

Best Regards

Dr. Sima Das

Director

For Dr Sima Das

Oculoplasty and Ocular Oncology Services

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