SRE C-26-03-0586

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

Koshika foundation
Building block of life.

APPLICATION No. आवेदन संख्या: S|0326|0987

APPLICATION DATE: आवेदन तिथि: 12|3|26

NAME of APPLICANT: आवेदक का नाम: Mr. Tellu Ram

AGE-YEARS आयु-वर्ष: 88

SEX लिंग: M

FATHER'S/SPOUSE'S NAME: पिता/पति का नाम: Late Mr. Ighri

PRESENT RESIDENCE ADDRESS: वर्तमान आवासीय पता: Ighri, Igau, Saharanpur, Uttar Pradesh, 247001

PERMANENT RESIDENCE ADDRESS: स्थाई आवासीय पता: same as above

PASTE PHOTO HERE

Pre op Post op
Tellu Ram
(0987)

OCCUPATION: Labour

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: कुल वार्षिक आय: 52,000

(Attach Proof of Income) (आय का साक्ष्य संलग्न) NA

PAN No. पैन नंबर: NA

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (जो लागू हो उस पर सही का निशान लगायें): Yes / No हाँ / नहीं

FAMILY DETAILS परिवार विवरण

Sr. No. क्र. संख्या	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) आयु (वर्ष)	Gender लिंग	Relation with Applicant आवेदक के साथ संबंध
(1)	Puran	52	M	Son
(2)	Manoj	48	M	Son
(3)	Sita Devi	50	F	Daughter in law
(4)	Dipanshu	28	M	Grand Son
(5)	Nikhil	29	M	Grand Son
(6)				

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

BPL Card (Attach Card Copy) गरीबी रेखा से नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आर्थ 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 निवेदन का उद्देश्य:

Sr. No. क्र. संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से प्राप्त की गई प्रतिवेदन सूची संलग्न
	Diagnosis- RE- Senile Cataract LE- Senile Cataract Surgery - RE- SICS with PMMA

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

Sr. No. क्र. संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि

DECLARATION by APPLICANT [illegible]

1) I hereby confirm that [illegible] in this Form are True to the best of my knowledge. Any false statement will render my Application & ongoing assistance, if any, [illegible]

2) I [illegible] 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 [illegible]

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 Hindi text]

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 Hindi text]

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

[illegible Hindi text]

P-self

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 [illegible] states that the Hospital will not avail any duplicate assistance for the same patient/case from any other NGO or any other source.

2) [illegible] from Koshika Foundation is only financial in nature. The choice of the treatment/procedure advised/conducted by the Hospital on the [illegible] is based on the engagement between the patient & the Hospital, and is in no way influenced by Koshika Foundation. Hence, the Hospital will [illegible] responsibility of the treatment & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility [illegible]

[illegible Hindi text]

RECOMMENDED FOR ACCEPTENCE
स्वीकृति के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख 12/3/26	Dr. NEHA DMC No.-58989 (Name of Dr. & Regd. No. with Stamp) डाक्टर का नाम व पंजीकरण नं० मुहर सहित	Dr. Shroff's Charity Eye Hospital, Mohand, Saharanpur (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी

FOR INTERNAL USE of KOSHIKA FOUNDATION आन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी हस्ताक्षर 1	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2