SRE-C-26-03-0571

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

Koshika foundation
Building block of life

APPLICATION No.: S|0326|0990
APPLICATION DATE: 12|3|26

NAME of APPLICANT	AGE-YEARS	SEX
Mrs. Mahendei	57	F

PASTE PHOTO HERE

FATHER/SPOUSE'S NAME: Late Mr. Ramkumar

PRESENT RESIDENCE ADDRESS: VILL PAHALWANPUR SHIKARPUR Uttar Pradesh – 247232

PERMANENT RESIDENCE ADDRESS: Same as above

Pre op Post op - Mahendei (0990)

OCCUPATION: Labour

MARRIED / UNMARRIED

TOTAL ANNUAL INCOME: 47,000

(Attach Proof of Income) NA

PAN No.: NA

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

FAMILY DETAILS

Sr. No.	Name of Family Member	Age (Years)	Gender	Relation with Applicant
(1)	Pusum	55	F	Wife
(2)	Arjun	26	M	Son
(3)	Sachin	23	M	Son
(4)	Vivek	20		

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:

Sr. No.	Medical Reports/Prescriptions Attached
	Diagnosis - RE- Senile Cataract LE- Senile Cataract Surgery - RE- SICS with PMMA

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

Sr. No.	NAME of OTHER SOURCE	AMOUNT of ASSISTANCE BEING AVAILED

DECLARATION by APPLICANT [illegible]

1) [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) [illegible] assistance, if received from Koshika Foundation, will be used only for the "purpose", as stated in this Form, for which such assistance [illegible]
3) [illegible] 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 [illegible] is requested.

[illegible]

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

1) [illegible] on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's Trustees to [illegible] my name, address, photo & details of the "purpose", for which such assistance is requested/granted, through any [illegible] verbal, print, electronic, for soliciting donations for Koshika Foundation and/or disseminating information about it's [illegible]. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfilment of the "purpose" [illegible]
2) [illegible] any such use of my name, address, photo & details of the "purpose", for which such assistance is requested/granted, [illegible] 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]

P-Self

AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

[illegible] signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we [illegible] accept following:
1) [illegible] not will in future avail of financial assistance from another NGO or any other source, for the same patient/case, as we are [illegible] 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] 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 [illegible] 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]

RECOMMENDED FOR ACCEPTENCE
स्वीकृति के लिए संस्तुति

Date of Surgery [illegible] 1/2/3/26	Dr. NEHA DMC No.-58989 (Name of Dr. & Regn. No. with Stamp) डाक्टर का नाम व हस्ताक्षर व रजि. न.	Dr. Shroff's Charity Eye Hospital, Manani, Saharanpur (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्ताक्षर 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
[signature]	[signature]

01.12.2022