SRE-C-26-03-0576

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

Koshika foundation
Building block of life

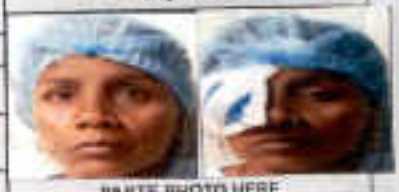
APPLICATION No.: S/0326/0991
APPLICATION DATE: 12/3/26

NAME of APPLICANT	AGE-YEARS आयु-वर्ष	SEX लिंग
Mrs. Premvati	58	f

FATHER'S/SPOUSE'S NAME: Mr. Ashok Kumar

PRESENT RESIDENCE ADDRESS: House no - 57 Rampur Road, Gram - Kalyanpur, Kalyanpur, Sahaspur, Saharanpur, Uttar Pradesh, 247232

PERMANENT RESIDENCE ADDRESS: same as above



PASTE PHOTO HERE

Pre op Post op Premvati (0991)

OCCUPATION: Home Maker

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME: 49,000 (Family Income)

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

PAN No.: NA

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

FAMILY DETAILS परिवार विवरण

Sr. No.	Name of Family Member परिवार के सदस्यों का नाम	Age (Years) उम्र (वर्ष)	Gender लिंग	Relation with Applicant आवेदक से साथ सम्बंध
(1)	Ashok Kumar	58	M	Husband
(2)	Ritik	29	M	Son
(3)	Tushar	35	M	Son
(4)	Mayank	31	M	Son

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

BPL Card (Attach Card Copy)	EWS Certificate (Attach Certificate Copy) प्रमाण आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) राशनकार्ड 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 प्रतिवेदन सूची संलग्न
	Diagnosis- RE- Senile Cataract LE- Senile Cataract Surgery - RE- SICS with PCIOL

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. क्रम संख्या	NAME of OTHER SOURCE अन्य स्त्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशी

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, [illegible] [illegible]

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

3) [illegible] in future, avail of reimbursement, in part or in full, from any other source/employer/insurance company, of the amount [illegible] requested.

[illegible]

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

[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] for soliciting donations for Koshika Foundation and/or disseminating information about it's [illegible] can be made by Koshika Foundation before or after my treatment or fulfilment of the "purpose" [illegible]

2) [illegible] 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 [illegible] 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 (अस्पताल द्वारा करार)

[illegible] signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we [illegible] following:

1) [illegible] will in future avail of financial assistance from another NGO or any other source, for the same patient/case, as we are [illegible] Koshika Foundation, to the extent that such assistance is granted by Koshika Foundation. If the requested assistance is not granted [illegible] 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) [illegible] 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] of the treatment & it's outcome & safety of the patient, and Koshika Foundation will have no role or responsibility [illegible]

[illegible]

RECOMMENDED FOR ACCEPTENCE
स्वीकृती के लिए संस्तुति

[illegible] 12/3/26	Dr. NEHA DMC No.-58989 (Name of Dr. & Regn. No. with Stamp) [illegible]	Dr. Shroff's Charity Eye Hospital, Manani, Saharanpur (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) [illegible]

FOR INTERNAL USE of KOSHIKA FOUNDATION [illegible]

SIGNATURE of TRUSTEE 1 [illegible]	SIGNATURE of TRUSTEE 2 न्यासी हस्ताक्षर 2

01.12.2022