

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika
foundation

Building Block of life.

APPLICATION No. :

आवेदन संख्या :

B/0125/3058

APPLICATION DATE :

आवेदन तिथि

09/01/2025

NAME of APPLICANT :

आवेदक का नाम

Nataraj Y.B.

AGE-YEARS आयु-वर्ष

61

SEX लिंग

M

FATHER'S/SPOUSE'S NAME :

पिता/कटुम्ब का नाम

SIO Basappa.

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

153, Haderanahalli, Arasikere Taluk

Tumkur District, Karnataka.

PERMANENT RESIDENCE ADDRESS : स्थाई आवासीय पता

OCCUPATION :

व्यवसाय

Coolie

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME :

कुल वार्षिक आय

21,000

(Attach Proof of Income)

(आय का सक्ष्य प्रस्तुत करें)

PAN No. स्थाई खाता संख्या

ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable):

मैं आय कर दाता हूँ (जो सत्य हो उस पर सही का निशान लगाएं)

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 सम्बन्ध
1	Vijayakumari	56	F	Wife

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिये विनति 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) उपभोक्ता कार्ड (प्रमाण पत्र की छाया प्रति संलग्न करें)	☐ Any Other Basis/Proof अन्य कोई साक्ष्य
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"PURPOSE" for REQUESTING ASSISTANCE:

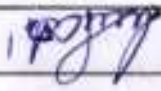
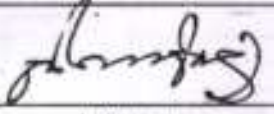
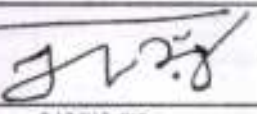
सहायता हेतु किये गये विनती का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
1	Diagnosis Rt Cataract. L Cataract.
2	Surgery L Cataract + Pkt

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

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

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशि
1	D301	2000/-

DECLARATION BY APPLICANT: ☐ 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, if any, 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. 4) I agree that if the assistance is not granted, I will not be entitled to any refund of the amount already paid.		AGREEMENT BY APPLICANT (Applicant's Signature) 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorize Koshika Foundation and its Trustees to use/submit/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 its activities/achievements. Such use of my photo & details can be made by Koshika Foundation before or after my treatment or fulfillment 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.		APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION: 		AGREEMENT BY HOSPITAL (Hospital's Signature) By affixing hereunder, signature of our Authorized 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 its 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 & its outcome & safety of the patient, and Koshika Foundation will have no role or responsibility in the matter. 3) We the Hospital, request that the Hospital's financial assistance should be granted only for the purpose for which it is requested, and not for any other purpose. 4) We the Hospital, request that the Hospital's financial assistance should be granted only for the purpose for which it is requested, and not for any other purpose.	
RECOMMENDED FOR ACCEPTANCE 		Date of Surgery 07/11/25		Dr. Laxmi Dorennavar (Name of the Consultant) Consultant, Phaco & Refractive # 15/A, Thimmar Road, Kumbhari, Kumbhari Area (Address of the Consultant) Mr. Lakshmi N (Name of the Hospital Representative) Hospital Representative Signature			
SIGNATURE OF TRUSTEE 1 		SIGNATURE OF TRUSTEE 2 		30-11-2024			