

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika
foundation

APPLICATION No. :

आवेदन संख्या :

B/0326/4124

APPLICATION DATE :

आवेदन तिथि

25/3/26

NAME of APPLICANT :

आवेदक का नाम

Shanthama

AGE-YEARS आयु-वर्ष

75

SEX लिंग

F

FATHER'S/SPOUSE'S NAME :

पिता/कटुम्भ का नाम

N/o Rangaswamy

PRESENT RESIDENCE ADDRESS वर्तमान आवासस्थान पता

Hoggarth Aravind (N)

Hosur (N) Kalralake

PERMANENT RESIDENCE ADDRESS : स्थाई आवासस्थान पता

pre op - post op
01124 - Shanthama

OCCUPATION :

व्यवसाय

Home maker

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME :

कुल वार्षिक आय

(Attach Proof of Income)

(आय का साक्ष्य संलग्न)

PAN No. स्थाई खाता संख्या

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

क्या आप आय कर दाता हैं (जो मान्य 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	Siddharangaswamy	70	m	Her husband

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिए 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 - pterid LT - cataract
2	Surgery :- LT - cataract + pterid

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

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

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED ली गई सहायता राशी

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, 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.

- AGREEMENT by APPLICANT (संबंधित व्यक्ति द्वारा)

- 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 (हस्पताल द्वारा कएल)

(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.

2. "कोशिका काउन्टेशन" से तो गई सहायता केवल कृत्रिम प्रकृति की है। रोगी पर हमलात द्वारा दो गई सलाह या किये गये उपचार/प्रक्रिया का चुनाव रोगी एवं हमलात के बीच का विषय है और "कोशिका काउन्टेशन" द्वारा किसी प्रकार का कोई रायश नहीं है। इसलिये हमलात में रोगी को इलाज सुरक्षा और अपने जाने की सारी जिम्मेदारी रोगी एवं हमलात की होगी और "कोशिका" की कोई भूमिका या जिम्मेदारी इस मामले में नहीं होगी।

RECOMMENDED FOR ACCEPTANCE

स्वीकृती के लिए संस्तुति

Date of Surgery
ऑपरेशन की तारीख

25/3/26

Dr. PREETHI. B.K.
M.B.B.S., D.O., F.I.C., F.P.S.
(Name of Dr. & Regn. No. with Stamp)
डा. प्रीति. बी.के.
एम.बी.बी.एस., डी.ओ., एफ.आई.सी., एफ.पी.एस.

FOR INTERNAL USE OF

Mr. LAKSHMIPATHI N

(Name, Designation & Stamp of Authorised Signatory)

OUTREACH BANGLADESH
DIABETES & EYE HOSPITAL

FOR INTERNAL USE of KOSHIKA FOUNDATION

(A Unit of Shraddha Eye Care Trust)

SIGNATURE of TRUSTEE 1

न्यासो हस्ताक्षर ।

VASSIGNATURE dITRUSTEE-52

न्यासी हस्ताक्षर 2