

C18/05/0047

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APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)

Koshika

APPLICATION No.:

A/0518/0070

APPLICATION DATE: 04/05/18

आवेदन संख्या:

आवेदन तिथि

NAME of APPLICANT:

Shanti

आवेदक का नाम

AGE-YEARS आयु-वर्ष

70

SEX लिंग

F

FATHER'S/SPOUSE'S NAME:

Nathu Ram

पिता/सहोदर का नाम

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

Village - Harasana, Teh - Bansur,

Dist. - Alwar, Rajasthan

PERMANENT RESIDENCE ADDRESS: स्थायी आवासीय पता

as above

OCCUPATION:

Labourer

व्यवसाय

TOTAL ANNUAL INCOME:

65,000

(Attach Proof of Income)

(आप का आय प्रमाण)

NA

PAN No. स्थायी खाता संख्या

NA

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

Yes ☐ No ☒

क्या आप आय का दाता हैं (जो लागू हो उस पर सही का निशान लगाएं)

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 संबंध
1	शान्ति देवी	70	F	मरीज
2	सुमान	40	M	पुत्र
3	सतीश	35	M	पुत्र

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिए बिंदी आधार

BPL Card (Attach Card Copy) गरीबी रेश के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया प्रति संलग्न करें)	Ration Card (Attach Copy) उपभोक्त्य 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 बिंदु चयन करने निम्नी का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई डॉक्टरों सूची संलग्न
1	Diagnosis — RF - IMSC LE - IMSC
2	Surgery — LE - SIC&+IOL

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

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

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED लेई गई सहायता राशि
1	SCEH	

Pre OP Post OP
0070 Shanti

DECLARATION by APPLICANT: सर्वोक्त हस्त पोषण वन

- 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 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 expenses for which this assistance is requested.
- 1) मैं घोषणा करता हूँ कि इस प्रत्येक में दिये गये सभी विवरण सही जानकारी के अनुसार सत्य एवं सही है। यदि कोई विवरण एवं कथन असत्य पाया जाता है तो मेरी सहायता निम्न की जा सकती है।
- 2) मैं इस जो सहायता यदि "कौशल विकास" के लिए की जा रही है, उसका उपयोग उसी उद्देश्य की पूर्ति के लिये किया जाएगा, जो इस प्रत्येक में उल्लेख किया गया है।
- 3) मैं घोषणा करता हूँ कि जिस सहायता हेतु यह प्रत्येक की जा रही है, उस राशि का अतिरिक्त या समकल विवरण किसी अन्य स्रोत/रोजगारदाता/कम्पनी से न तो लिया है और न हो लिये जा सके।

AGREEMENT by APPLICANT (applicable to 4702)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its Trustees to use/publish/post-up/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 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.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION _____

आपरेक को हस्ताक्षर या अंगूठे का निशान

ਅੰਤਰਰਾਸ਼ਟਰੀ
ਦਾਇਰਾ

AGREEMENT by HOSPITAL (PRINT OR TYPE)

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 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.

RECOMMENDED For (Tick Acceptance or Rejection as applicable) संस्तुति (स्वीकृत/निरस्त का चिह्नन लगाये)		ACCEPTANCE मंजूर		REJECTION नमंजूर	
Date of Surgery ऑपरेशन की तारीख 05/05/18					
FOR INTERNAL USE of KOSHIKA FOUNDATION					
		SIGNATURE of TRUSTEE 1 नया हीरका 1		SIGNATURE of TRUSTEE 2 नया हीरका 2	
SANCTIONED संस्तुति	REJECTED नमंजूर				