

C18/05/0027

APPLICATION FORM FOR ASSISTANCE
सहायता हेतु आवेदन प्रारूप

(Healthcare)
(स्वास्थ्य देखभाल)

Koshika
foundation
Building block of life

APPLICATION No. : आवेदन संख्या : V/0518/0132 APPLICATION DATE : आवेदन तिथि : 04/05/2018

NAME of APPLICANT : आवेदक का नाम : Deviram AGE-YEARS आयु-वर्ष : 64 SEX लिंग : M

FATHER'S/SPOUSE'S NAME : पिता/कटुप का नाम : Slo murtidhak

PRESENT RESIDENCE ADDRESS : वर्तमान आवासोप पता

H.No - 84, Vill/Mohla - Saikhond Khana, Teh - Sadar
Dist - Mathura, U.P. 281204

PERMANENT RESIDENCE ADDRESS : स्थाई आवासोप पता

same as above

OCCUPATION : व्यवसाय : Farmer

TOTAL ANNUAL INCOME : कुल वार्षिक आय : 2500/- (Attach Proof of Income) (आय का साक्ष्य संलग्न) NA

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 ☒ हाँ

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.	<u>Roosha Devi</u>	<u>60</u>	<u>F</u>	<u>Wife</u>
2.	<u>Komal Singh</u>	<u>45</u>	<u>M</u>	<u>Son</u>
3.	<u>Mahaveer</u>	<u>40</u>	<u>M</u>	<u>Son</u>
4.	<u>Yogendra</u>	<u>35</u>	<u>M</u>	<u>Son</u>

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

BPL Card (Attach Card Copy) गरीबी रेश का नौपै 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
	<u>RE -> Tmsc</u>
	<u>LE -> Tmsc</u>
	<u>Surgery -> (LE) SICS WITH TOL</u>

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES
इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिप्त क्या हो?

Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम	AMOUNT of ASSISTANCE BEING AVAILED सी गई सहायता राशी
1.	<u>S.C.E.H</u>	

Preop Postop
(0132) Deviram.

DECLARATION by APPLICANT: (आवेदक द्वारा घोषणा करें)

- 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.
- 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.
- 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.
- मैं यहाँ घोषणा करता हूँ कि इस प्रारूप में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण एवं कथन असत्य पाया जाता है तो मेरी सहायता निरस्त की जा सकती है।
- मैं यहाँ घोषणा करता हूँ कि "कोशिका फाउन्डेशन", से यदि मैं सहायता प्राप्त करता हूँ, तो मैं इसे केवल उसी उद्देश्य के लिए ही प्रयोग करूँगा, जो इस प्रारूप में स्पष्ट रूप से बताया गया है।
- मैं यहाँ घोषणा करता हूँ कि मैं किसी भी अन्य स्रोत, नियोक्ता या बीमा कंपनी से उस राशि के लिए कोई भी भुगतान नहीं करूँगा, जिसके लिए मैं इस सहायता के लिए अनुरोध कर रहा हूँ।

AGREEMENT by APPLICANT (आवेदक द्वारा करार)

- By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and its Trustees to use/publish/print-up/produce 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.
- 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.
- इस प्रारूप पर अपने हस्ताक्षर या अंगूठे का निशान लगाकर, मैं (आवेदक) यहाँ घोषणा करता हूँ कि मैं "कोशिका फाउन्डेशन और इसके भरोदारों" को अधिकृत करता हूँ कि वे मेरा नाम, पता, फोटो और मेरे विवरण इस प्रारूप में घोषित करें, जो "कोशिका फाउन्डेशन" द्वारा उद्देश्य के लिए धन/सहायता प्राप्त करने के लिए प्रयोग किया जा सकता है।
- मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण को "कोशिका फाउन्डेशन" द्वारा उद्देश्य के लिए प्रयोग किया जा सकता है।
- मैं (आवेदक) इस बात से सहमत हूँ कि मेरा नाम, पता, फोटो और विवरण को "कोशिका फाउन्डेशन" द्वारा उद्देश्य के लिए प्रयोग किया जा सकता है।

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

आवेदक के हस्ताक्षर या अंगूठे का निशान

AGREEMENT by HOSPITAL (हस्पताल द्वारा करार)

- 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:
- 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.
 - 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.
- हम यहाँ घोषणा करते हैं कि हम (हस्पताल) निम्न प्रकार से मान्यता दे रहे हैं:
- 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.
 - 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.

RECOMMENDED FOR ACCEPTANCE

स्वीकृति के लिए संस्तुति

Date of Surgery ऑपरेशन की तारीख	Dr. Ashwini Kumar MBBS, MS, FICO Reg. No. 66028 (Name of Dr. & Regn. No. with Stamp) डॉक्टर का नाम व हस्ताक्षर व मुद्रा	(Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद हस्पताल अधिकृत अधिकारी
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FOR INTERNAL USE of KOSHIKA FOUNDATION (आंतरिक उपयोग हेतु)

SIGNATURE of TRUSTEE 1
भरोदार 1 का हस्ताक्षर

[Signature]

SIGNATURE of TRUSTEE 2
भरोदार 2 का हस्ताक्षर

[Signature]