

APPLICATION FORM FOR ASSISTANCE

सहायता हेतु आवेदन प्रारूप

(Healthcare)

(स्वास्थ्य देखभाल)



APPLICATION No. :

आवेदन संख्या :

K/0119/2383

APPLICATION DATE :

आवेदन तिथि

28/01/19

NAME of APPLICANT :

आवेदक का नाम

SARASWATI DAS

AGE-YEARS आयु-वर्ष

62

SEX लिंग

F.

FATHER'S/SPOUSE'S NAME :

पिता/सहोदर का नाम

AMULYA DAS

PRESENT RESIDENCE ADDRESS वर्तमान आवासीय पता

225/H/145, KANAKMART ROAD, KANAKMART, KOLKATA 700054 WEST BENGAL.

PERMANENT RESIDENCE ADDRESS : स्थायी आवासीय पता

— AS ABOVE —

OCCUPATION :

व्यवसाय

HOMEMAKER

MARRIED (विवाहित) / UNMARRIED (अविवाहित)

TOTAL ANNUAL INCOME :

कुल वार्षिक आय

NIL.

(Attach Proof of Income)

(आय का साक्ष्य संलग्न)

PAN No. स्पष्ट खाली रखें

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

हां / 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.	SARASWATI DAS	62	F	SELF
2.	AKHIL DAS	46	M	SON
3.	SHRUTI MALIKAR	34	F	DAUGHTER
4.	ANITA GHOSH	35	F	DAUGHTER

BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable)

सहायता के लिये विधि आधार

BPL Card (Attach Card Copy) गरीबी रेशा 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) उपभोग्य 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 किसी का उद्देश्य:

Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached अस्पताल/डॉक्टर से जारी की गई प्रतिवेदन सूची संलग्न
1.	DIAGNOSIS- CATARACT- L.E.
2.	SURGERY- L.E (SICS+IOL)

ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES

इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिए गए हैं?

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

DECLARATION by APPLICANT: **ਅਰਜ਼ਦਾਰ ਦੁਆਰਾ ਘੋਸ਼ਣਾ ਹੈ:**

- 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.
- 1) मैं यहाँ पर बताना हूँ कि इस प्रकरण में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण पूर्ण रूप से असत्य पाया जाता है तो मेरी सहायता निरास की जा सकती है।
- 2) मैं इस को सहायता एतल "कोशिका फाउन्डेशन", से ही प्राप्त करूँगी, इसका उपयोग उन्ही उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रकरण में पता होगा है।
- 3) मैं यहाँ पर बताना हूँ कि बिना सहायता हेतु मैं अन्यत्र से भी पैसा नहीं लेऊँगी, या एतल या अन्यत्र से पैसा किसी अन्य सोर्स/एम्प्लॉयर/इन्सुरेन्स कंपनी से न ले लिये है और न ही भविष्य में लूँगा।

AGREEMENT by APPLICANT (above do not)

- 1) By affixing my signature or thumb impression on this Form, I (Applicant) hereby agree & authorise Koshika Foundation and it's 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 it's 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 :

आलेखक को इलाहाबाद का अंग्रेजी का निवास



AGREEMENT by HOSPITAL (हस्पताल द्वारा स्वीकृति)

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 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 ACCEPTENCE

स्वीकृती के लिए संसुति

Date of Surgery अस्त्रोपचार की तारीख 08-01-2019	Dr. Archya Das MBBS, MS Reg. No. - 69372 (Name of Dr. & Reg. No. with Stamp) डाक्टर का नाम व इलाका व संकेत	Subho Senkar Bagchi Director Subho Foundation & Research Centre (Name, Designation & Stamp of Authorised Signatory on behalf of Hospital) नाम व पद इलाका व अधिकृत अधिकारी
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FOR INTERNAL USE of KOSHIKA FOUNDATION ज्ञानवैदिक उपयोग हेतु

SIGNATURE of TRUSTEE 1 न्यासी इमदाद 1	SIGNATURE of TRUSTEE 2 न्यासी इमदाद 2
	