

APPLICATION FORM FOR ASSISTANCE (Healthcare)				(सहायता हेतु आवेदन प्रारूप)		 Koshika foundation Building block of life	
APPLICATION No. : आवेदन संख्या :			K/0119 / 2790			APPLICATION DATE : आवेदन तिथि	
NAME of APPLICANT : आवेदक का नाम			BHAGIYA ROUTH			AGE-YEARS आयु-वर्ष	
			80			SEX लिंग	
			F				
FATHER'S/SPOUSE'S NAME : पिता/पति का नाम							
NIRAB ROUTH							
PRESENT RESIDENCE ADDRESS : वर्तमान निवासस्थान पता							
DARSHIN BANSAHALA MANDAL DARGA KUPANADI							
HASNABAD NARAIYA PHALGONA 743495							
NBI7 MANDAL							
PERMANENT RESIDENCE ADDRESS : स्थायी निवासस्थान पता							
- AS ABOVE -							
OCCUPATION : व्यवसाय						MARIED (विधवा) / UNMARRIED (अविधवा)	
HOME MAKER.						☒ ☐	
TOTAL ANNUAL INCOME : कुल वार्षिक आय						(Attach Proof of Income) (आय का सबूत संलग्न)	
NIL							
PAN No. : स्थायी आयकर पहचान संख्या							
ARE YOU AN INCOME TAX ASSESSEE (Tick whichever is applicable): क्या आप आय कर दाता हैं (जो मान्य हो उस पर सही का चिह्न 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	ANUSHA ROUTH	80	F	SELF			
2	MAHESU PAWISH	54	F	DAUGHTER			
3	MURALI ROUTH	54	F	DAUGHTER			
BASIS for REQUESTING ASSISTANCE (Tick whichever is applicable) सहायता के लिए विनियमित आधार							
BPL Card (Attach Card Copy) गरीबी रेषा के नीचे प्रमाण पत्र (प्रमाण पत्र की छाया छवि संलग्न करें)		EWS Certificate (Attach Certificate Copy) आय आय वर्ग प्रमाण पत्र (प्रमाण पत्र की छाया छवि संलग्न करें)		Ration Card (Attach Copy) उपभोग्यता कार्ड (प्रमाण पत्र की छाया छवि संलग्न करें)		Any Other Basis/Proof अन्य कोई सबूत	
"PURPOSE" for REQUESTING ASSISTANCE: सहायता हेतु किने गये निती का उद्देश्य:							
Sr. No. क्रम संख्या	Medical Reports/Prescriptions Attached रिपोर्ट/डॉक्टर से जारी की गई प्रिलिखित सूची संलग्न						
1	DIAGNOSIS - CATARACT - RE						
2	SURGERY - RE (SALVAGE)						
ASSISTANCE BEING AVAILED for SAME "PURPOSE" from OTHER SOURCES इस उद्देश्य के हेतु कोई अन्य सहायता किसी अन्य स्रोत से लिये गया हो?							
Sr. No. क्रम संख्या	NAME of OTHER SOURCE अन्य स्रोत का नाम				AMOUNT of ASSISTANCE BEING AVAILED शी गई सहायता राशि		

DECLARATION by APPLICANT: ☐ I am a citizen of the United States. ☐ I am a resident alien. ☐ I am a nonresident alien.

- 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 घोषणा करता हूँ कि इस प्रश्न में दिये गये सभी विवरण मेरी जानकारी के अनुसार सत्य एवं सही हैं। यदि कोई विवरण सत्य नहीं माना जाय या यह साबित हो जाय कि यह सत्य नहीं है तो मेरी सहायता निरस्त की जा सकती है।
- 2) मैं घोषणा करता हूँ कि "कोशिका फाउण्डेशन", से ली जा रही है, उसका उपयोग उक्त उद्देश्य की पूर्ति के लिये किया जायेगा, जो इस प्रश्न में वर्णित है।
- 3) मैं घोषणा करता हूँ कि मैं किसी सहायता हेतु या प्रत्यक्ष की गई है, उस पर या अप्रत्यक्ष या समस्त विवरण किसी अन्य स्रोत/रोजगार/बीमा कंपनी से या से लिया है और यही घोषणा मैं करता हूँ।

AGREEMENT by APPLICANT (where not used)

- 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 is this regard will be final and acceptable to me.

APPLICANT'S SIGNATURE OR LEFT THUMB IMPRESSION:

अपेक्षित है। इसका मतलब यह है कि यह विचार



AGREEMENT by HOSPITAL: (WHICH DO YOU)

By affixing hereunder, signature of our Authorised Signatory for recommending this case/patient for financial assistance from Koshika Foundation, we (Hoschika) hereto 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 ACCEPTANCE

संवीकृती के लिए संभारित

Date of Surgery
ਅੰਮ੍ਰਿਤਸਰ ਦੀ ਤਾਰੀਖ

24/04/19

Dr. Arun Ray
B.S., M.S., FPOS
Reg. No. 18853-AMC
Sri Ram Eye Foundation & Research Centre

Shib Sankar Bagchi,
Director
(Name, Designation & Stamp of Authorized Signatory
on behalf of Hospital)
নাম ও পদ প্রদানের অধিকৃত অফিসার

FOR INTERNAL USE of KOSHIKA FOUNDATION अन्तरिक उपयोग हेतु

SIGNATURE of TRUSTEE 1
न्यासी इमानत ।

Exchanged

SIGNATURE of TRUSTEE 2
आशी बरमान 2

2020